RIVERVIEW HEALTH CENTRE

RESEARCH ACCESS FORM

Please submit this access form, all materials provided for the ethical review process, ethical approval letter, instruments to be used, PHIA, and any other documents for the access review, preferably as a single pdf.

A. **IDENTIFICATION**

Principal Investigator: _____

Address: _____

Telephone Number: _____

Fax Number: _____

E-mail Address: _____

Title of Study: _____

Other Team Members: _____

Date: _____

B. **AFFILIATION**

Complete as appropriate:

i) **Student** Yes _____ No _____

If Yes:

Faculty Advisor: _____

Educational Institution: _____

Faculty/Department: _____

Address: _____

Thesis: Yes _____ No _____

If not Thesis, course for which research is required: _____

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ii) **Riverview Employee** Yes _____ No _____

Department: _____

Supervisor: _____

iii) **Other**

Position: _____

Organization: _____

Dean/Director/Supervisor: _____

Telephone Number of Dean/Director/Supervisor: _____

C. **ETHICAL APPROVAL**

Date Ethical Approval Received: _____

Name of University from which Approval Obtained: _____

Please attach a copy of your **submission to the Ethics Review Board** and the **approval letter** from that board.

D. **PURPOSE AND SIGNIFICANCE OF STUDY**

Please identify both the purpose of the study and significance of this study for patients/residents and/ or the Riverview Health Centre (max 1,000 characters).

E. **TIME LINES FOR STUDY**

Anticipated Start Date for Data Collection: _____

Anticipated Duration of Project: _____

Predicted End Date: _____

F. **FUNDING**

Please identify sources and amount of funding for this project:

Source:	*Amount of Funding:*
	$
	$
	$

G. **RESOURCE REQUIREMENTS FROM RIVERVIEW HEALTH CENTRE**

i) Please briefly describe the study design and how you will collect data (including both sample recruitment and data collection methods). (max 1,300 characters). Append data collection tools as appropriate.

ii) If you require assistance from staff members of the Riverview Health Centre in the data collection process, please describe whose assistance is required, the nature of the assistance required, and the amount of time required.

iii) If you are requesting access to Health Information Department resources (e.g.: retrospective data extraction from charts), please outline exactly what information is required.

iv) List Riverview Health Centre supplies and/or equipment that may be required (e.g.: laboratory tests, X-ray requirements, etc.) and describe plans to cover expenses.

v) Identify space requirements (if any).

Add additional page(s) as required.

Suggested Designated Riverview Health Centre Contact

Name: _____

Riverview Health Centre Approval

Yes _____ No _____ Date: _____