UT Health San Antonio
Institute for Integration of Medicine & Science
Clinical Research Services

IIMS CLINICAL RESEARCH UNIT (CRU)

RESEARCH SERVICES INQUIRY

PLEASE READ CAREFULLY: The following information is needed in order to help us successfully develop cost sharing agreements and implement studies in the CRU. Complete all requested information in its entirety and return to FlemingL1@uthscsa.edu.

Section 1. Research Project

Full Protocol Title as Listed in IRB		
IRB Protocol Number		**Expected Completion Year of Study**
	☐ Approved ☐ Pending	
Funding Type	**Funding Source**	**Funding Status**
☐ Federal (VA, DOD, NIH, etc.) ☐ Industry ☐ Foundation ☐ Other		☐ Funded ☐ Pending

Section 2. Research Team

Principal Investigator Name, Degree		
E-mail	**Office Phone**	**Cell Phone**
Primary Departmental Appointment	**Division**	**Specialty**
Study Coordinator	**Credentials**	**Official Job Title**
E-mail	**Office Phone**	**Cell Phone**

Section 3. Visit Information (General)

Estimated number of subjects expected to be seen	Estimated total number of visits per subject	Estimated Total Number of **Nursing Visits** for Duration of Study	Estimated Date for First Research Visit	Estimated Date for Final Research Visit

Section 4. Visit Information (Detail)

Service	**Visit (if there will be additional visits, please attach information)**									
	1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Purpose of visit (screening, treatment, etc.)										
Estimated Total Length of Visit										
Estimated Nursing Time Needed										
Pharmacy Services (Y/N)										
Lab Processing (Y/N)										
Visit Details										
Estimated time visit will start										
Will visit span beyond normal hours of operation? (Y/N)										
Food										
Meal Voucher Needed?										
Please include any additional information which will be helpful to us in implementing this study										