Canadian Center for Vaccinology
IWK Health Centre
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Clinical Research Unit
Request for Services

***Please include a copy of the Study Protocol (if applicable)**

FULL NAME	FACULTY/DEPT/SCHOOL/PROGRAM
POSITION	P.I. AFFILIATIONS ☐ IWK ☐ CDHA ☐ DAL ☐ Other
Phone	EMAIL
PROJECT TITLE	

PROJECTED TIMELINES FOR REQUEST

Visit Type (inpt/outpt)	Number of rooms	Start date	End date	Duration (if start/end dates unknown)

SERVICES REQUIRED

☐ **FACILITY**
- ☐ **Food services**

☐ **CLINICAL STAFF (provide details)**
- ☐ **On-call services (specify)**

☐ **DIAGNOSTIC**
- ☐ **Diagnostic imaging (specify)**
- ☐ **Lab**
- ☐ **Pharmacy**
- ☐ **Cardiology (e.g., EKG)**
- ☐ **Other (specify)**

☐ **PREPARATION OF ETHICS SUBMISSION**

☐ **RECRUITMENT**

☐ **RECORDS MANAGEMENT**
- ☐ **Case report form development**
- ☐ **Electronic data entry**
- ☐ **Other**

☐ **DATA MANAGEMENT/STATISTICAL. ANALYSIS**
- ☐ **Other**

ADDITIONAL COMMENTS

Please return the completed form to Cathy Brown, Clinical Coordinator at Catherine.brown@iwk.nshealth.ca or fax to: 902-470-7232

FOR OFFICE USE ONLY

DATE RECEIVED:		STUDY CODE ASSIGNED:
☐ Approved	Date:	Sign:
☐ Not approved Reason:	Date:	Sign: