**RESEARCH ETHICS BOARD – CHECKLIST OF RESOURCES**

Please complete the following information, and once you’ve obtained the appropriate signatures, submit this document, along with your REB application, to the REB admin office.

|  |  |
| --- | --- |
| **REB NUMBER:** Click here to enter text.**PRINCIPAL INVESTIGATOR:** Click here to enter text.**PROTOCOL TITLE:** Click here to enter text. | **DATE:** Click here to enter a date.**CURRENT PROTOCOL DATE:** Click here to enter text.**CURRENT PROTOCOL VERSION #:** Click here to enter text.**CURRENT ICF VERSION #:** Click here to enter text. |

1. **CLINICAL RESOURCES**

***Will any of the following hospital resources be impacted beyond what would normally be required for the usual clinical care of the patients/clients of The Royal?***

If “yes,” for any of the resources listed below, list the tests/exams that are applicable in the column provided in the table below.

|  |  |  |  |
| --- | --- | --- | --- |
| **Clinical Area** | **Yes** | **No** | **List Required Tests/Exams** |
| Pharmacy |[ ] [ ]  Click or tap here to enter text. |
| Laboratory |[ ] [ ]  Click or tap here to enter text. |
| Radiology |[ ] [ ]  Click or tap here to enter text. |
| Electroencephalography |[ ] [ ]  Click or tap here to enter text. |
| Other: Click or tap here to enter text. |[ ] [ ]  Click or tap here to enter text. |

1. **ADDITIONAL CLINICAL AND ADMINISTRATIVE SUPPORT**

***Will additional resources/support be required beyond that which is expected in usual clinical care of the patients/clients in the following areas? (Check all that apply)***

If “yes,” is selected for any of the resources listed below, explain the nature of the utilization in the column provided in the table below.

|  |  |  |  |
| --- | --- | --- | --- |
| **Resource Required** | **Yes** | **No** | **Explanation** |
| Nursing |[ ] [ ]  Click or tap here to enter text. |
| Occupational Therapy |[ ] [ ]  Click or tap here to enter text. |
| Psychology |[ ] [ ]  Click or tap here to enter text. |
| Recreational Therapy |[ ] [ ]  Click or tap here to enter text. |
| Clinical Records |[ ] [ ]  Click or tap here to enter text. |
| Social Work |[ ] [ ]  Click or tap here to enter text. |
| Dietary |[ ] [ ]  Click or tap here to enter text. |
| Other Administrative |[ ] [ ]  Click or tap here to enter text. |

**REMINDER**

If Grant Funding will cover research costs incurred by the Hospital, please indicate the source of the grant in the space below. Attach a detailed budget to the REB application upon submission.

1. **SIGNATURES**

Signatures for Resources

Applicable signatures are required when clinical resources and/or support will be impacted by research activities. Provide a copy of the protocol or a brief synopsis of how the research affects each area to the signatory so they are aware of the resources required.

Confirmation of Resource Usage

Please check all that apply and obtain the applicable signatures.

[ ]  **Laboratory, Imaging, EKGs, EEGs**

**Lisa Kis (ROMHC)** Email: Lisa.Kis@theroyal.ca Phone: Ext. 6968

**Emily Deacon (ROMHC, BMHC)** Email: Emily.Deacon@theroyal.ca Phone: Ext. 6774

Name: Click here to enter text. Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Signature: Click here to enter a date.

[ ]  **Nursing**

**Billie Pryer (ROMHC)** Email: Billie.Pryer@theroyal.ca Phone: Ext. 6060

Name: Click here to enter text. Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Signature: Click here to enter a date.

[ ]  **Clinical Records**

**Colleen Gemmell (ROMHC, BMHC)** Email: Colleen.Gemmell@theroyal.ca Phone: Ext. 6328

Name: Click here to enter text. Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Signature: Click here to enter a date.

[ ]  **Pharmacy**

**Tabitha Burta (ROMHC, BMHC)** Email: Tabitha.Burta@theroyal.ca Phone: Ext. 6723

Name: Click here to enter text. Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Signature: Click here to enter a date.

[ ]  **Other:**

**Name:** Click here to enter text. Email: Click here to enter text. Phone:

 Ext.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Signature: Click here to enter a date.

1. **ADMINISTRATIVE SIGN-OFF**

Administrative sign-off is required. If the administrative signatory is listed as a PI or co-investigator, then an alternate administrative sign-off is required (e.g. IMHR CEO, COO, etc.)

**Required Signatures:**

**Principal Investigator**

Name: Click here to enter text. Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Signature: Click here to enter a date.

**Research Unit Director**

Name: Click here to enter text. Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Signature: Click here to enter a date.

***You must keep a copy of this completed form for your study file***