PROGRAM UTILIZATION

This Form must be completed if access to a BC Children's Hospital Program is required. Please complete ALL questions and obtain the necessary signature(s). A form must be submitted for each Program that your study impacts upon.

Principal Investigator:

REB#:

Name of Sponsor:

Study Start Date:

Study End Date:

Project Title:

Primary Contact:

Email:

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1. Indicate the Program(s) in which the study will be carried out:

BC CHILDREN'S HOSPITAL	**CHILD & YOUTH MENTAL HEALTH / SUNNY HILL HEALTH CENTRE**
☐ Acute & Critical Care ☐ PICU ☐ ER ☐ NS ☐ CS ☐ Resp. ☐ Medical Specialties and General Pediatrics ➢ Specify Department: ☐ Oncology/Hematology/BMT ☐ Surgery & Surgical Suites ☐ Anesthesia ☐ Other ➢ Specify:	☐ Child & Youth Mental Health ☐ Child Development & Rehabilitation ☐ (SHH) Other ➢ Specify:

2. Hospital venue: ☐ Clinic ☐ Day Care ☐ ER ☐ OR ☐ Inpatient bed ☐ PICU (check those that apply)

3. How many subjects will be participating at the BCCH site?

4. How many controls will be participating at the BCCH site?

5. List tasks required of **Hospital Employees** in this Program for this study, by Hospital Area:

6. List study activities conducted in the Program by **non-Program Staff** (e.g. research/lab personnel):

It is the responsibility of the Programs to determine if these services will have sufficient impact as to require recovery from the research study budget to offset hospital operating costs. It is the responsibility of the Programs to provide investigators with the cost of those services.

7. It is the Investigator's responsibility to orient staff that will be involved in this study. If applicable, describe how Hospital employees in this Program will be oriented to this study.

As a condition for ongoing institutional approval, you may be contacted annually for updates on the number of participants recruited, study results, publications, and media coverage.

SIGNATURES:

BC CHILDREN'S HOSPITAL

Signature: _____

Print Name: _____

Position: _____

(Medical Director or Program Director/SDO)

CHILD AND YOUTH MENTAL HEALTH

Signature: _____

Print Name: _____

Position: _____

(VP Medical Affairs, Senior Medical Director, Executive Director, or Program Director/SDO)

SUNNY HILL HEALTH CENTRE FOR CHILDREN

Signature: _____

Print Name: _____

Position: _____

(Program Manager, Discipline Lead, Senior Medical Director or Senior Director/SDO)

***For a list of Program/Resource Signing Authorities please visit the C&W UBC REB website:**

http://www.phsa.ca/researcher/ethics-approvals/institutional-approvals