

**PROGRAM UTILIZATION FORM**

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| This Form must be completed if your research study impacts a BC Women’s Hospital + Health Centre (BCWH) program or clinic. Refer to the [*BCWH Program Utilization Form Guidance Notes*](http://www.phsa.ca/researcher/Documents/BCWH%20PU%20Form%20Guidance%20Notes.docx) for information on institutional approval, program utilization, and the submission process. Note that this process generally takes at least 6-8 weeks. The Programs/Clinics are responsible for determining if these services will have sufficient impact as to require cost recovery. It is the responsibility of the Principal Investigator/Project Lead to ensure proper consultation is done with the Programs/Clinics prior to finalizing the project budget. |

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| **Principal Investigator/Project Site Lead Declaration**It is the responsibility of the Principal Investigator (PI)/Project Site Lead to inform the program/clinic and the Women’s Health Research Institute (whri\_cwbc@cw.bc.ca) in a timely manner (within 4 weeks) if there will be any potential or has been an actual change in the PI and/or Site Lead’s **BC Women’s Hospital medical staff privileges or appointment** during the study period, as this may impact the ability of the study to proceed. If a change in privileges or appointment may occur or has occurred, study approval will be re-reviewed by the program/clinic and by the Women’s Health Research Institute.Please select the declaration option below that best fits with the current research study:* The Principal Investigator overseeing the study holds an appointment with the Children’s & Women’s Health Centre of British Columbia.

As Principal Investigator, I understand it is my responsibility and agree to inform the program/clinic and the WHRI within 4 weeks of any potential or actual change in my BC Women’s Hospital + Health Centre medical staff privileges or appointment during the study period.Principal Investigator Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* The Principal Investigator has designated a Project Site Lead to oversee study activities who holds an appointment with the Children’s & Women’s Health Centre of British Columbia.

As designated Project Site Lead, I understand it is my responsibility and agree to inform the program/clinic and the WHRI within 4 weeks of any potential or actual change in my BC Women’s Hospital + Health Centre medical staff privileges or appointment during the study period.Project Site Lead Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Print Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Section 1: Project Information**

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| Study Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| REB#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  | REB Approval Date: Date  | [ ]  In progress |
| Principal Investigator Name: \_\_\_\_\_\_\_\_\_\_\_\_\_ | PI Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Primary Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Primary Contact Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Primary Contact Role: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(E.g., Researcher, learner-student, resident) | Study Sponsor (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Anticipated start date (in program): Date  | Anticipated end date (in program): Date  |
| Summarize the research proposal, including study purpose, study population, andresearch method (please be brief and use lay language): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Section 2: Supporting Documents**

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| Include the following documents (if applicable) with your PU Form before the signatories can review your request:  [ ]  Study/Project Protocol [ ]  RISe (Research Ethics) Application [ ]  Research Ethics Approval Certificate  [ ]  Consent Form(s)/ Waiver of consent [ ]  Patient Information Sheet [ ]  Recruitment Material (e.g., posters) [ ]  Service agreements (e.g., lab services, imaging, pharmaceutical) |

**Section 3: BC Women’s Hospital Program and/or Specific Clinic**
One form must be submitted for each program that is impacted by your study.

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| **ACUTE PROGRAMS** |
|  [ ]  Maternal Newborn Program:  [ ]  Antepartum/Postpartum Specify Unit(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *(Evergreen, Dogwood, Arbutus, Balsam)* [ ]  Cedar Birthing Suites [ ]  Teck L&D, OB Surgical Services, UCC Specify Area(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  [ ]  Perinatal Substance Use *(Fir square)*  |  [ ]  Neonatal Program:  [ ]  NICU [ ]  Neonatal Follow-up [ ]  MBC |
| **AMBULATORY PROGRAMS** |
|  [ ]  Maternity Ambulatory Program Specify Clinic(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *(I.e.,* *Anesthesia, Antepartum Homecare, Diabetes in Pregnancy, Fetal Assessment, Fetal, Diagnosis Service, Hematology, Infectious Diseases, Internal Medicine, Iron Infusions, Lactation Consultation, Maternal Fetal Medicine, New Beginnings Maternity,  Prenatal/Special Procedures, Social Work, Ultrasound).* |  [ ]  Nurse Practitioner Services Specify Clinic(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *(I.e., After Breast Cancer, Aboriginal Mother’s Centre (AMC), Vancouver Women’s Health Collective (VWHC), WISH drop-in Centre, Sisterspace Overdose Prevention Site (OPS), Heart Health, Newcomer Services).* |
|  [ ]  Gynecology and Sexual Health Program Specify Clinic(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  *(I.e., Chronic Pelvic Pain and Endometriosis, Early Pregnancy Assessment Clinic (EPAC), Recurrent Pregnancy Loss (RPL), ACCESS, Continence, CARE Program)* |  [ ]  Gynecology Daycare Surgical Services |
|  [ ]  Breast Health Program |  [ ]  Oak Tree Clinic |
|  [ ]  Sexual Assault Service |  [ ]  Provincial Medical Genetics Program |
|  [ ]  Complex Chronic Diseases Program |  [ ]  Penicillin Allergy Clinic  |
|  [ ]  Other, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
| *For a full list of BCWH Services:* [*http://www.bcwomens.ca/our-services*](http://www.bcwomens.ca/our-services) |

**Section 4 PROGRAM UTILIZATION REQUEST**

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| a) What BCWH Program/Clinic resource(s) are you requesting? Check all that apply. |  [ ]  Staff (e.g. booking clerk, nurse, health records tech) [ ]  Infrastructure (e.g., Exam Room, Equipment) [ ]  Clinic or Program Records [ ]  Parent Advisors (NICU) [ ]  Other, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [ ]  None |
| b) What tasks are being requested of Hospital Staff for this study?  |  [ ]  Introduce research study/staff to patient [ ]  Chart flagging [ ]  Chart access [ ]  Data entry [ ]  Sample collection [ ]  Other [ ]  None |
| c) How many research participants will be participating at BCWH (in this program specifically)?  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| d) Describe what is being requested **of Program Staff and/or Program resources** for this study.For Acute programs, if more than one clinic area was selected in Section 3, list requests for each area separately. For Ambulatory programs, where applicable, include the following:* Type of resource
* Duration (i.e. minutes/hours)
* Time (of day)
* Frequency (weekly, ad hoc)
* Start Date
* End Date
 | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| e) Describe study activities conducted in the Program by **non-Program Staff.***e.g., Research staff, trainees, research nurse* | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| f) If your study requires participant recruitment within a program, how will your study representative be introduced to the patient or family member?  | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| g) How will program staff be oriented to the study (or trained) if necessary? | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| h) How will the research results be shared with the program? | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| i) If required by the program, is funding available to support any requested BCWH Program/Clinic resources? |  [ ]  Yes [ ]  No |
| j) Please include any additional information about your study that would help during our review. | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| k) Would you like to promote your study on the BC Women’s Hospital website? |  [ ]  Yes [ ]  No |

**Please see next page for required signatures:**

For Acute Programs, please see Section **5.1**

For Ambulatory Programs, please see Section **5.2.A**; for Provincial Medical Genetics Program see Section **5.2.B**

To obtain signatures, please submit your PU Form request to:

**Acute: Maternal Newborn Programs**

* + Submit completed form and supporting documentation to Kathryn Dewar
	(kdewar@cw.bc.ca) who will assist with obtaining all necessary signatures.

 **Acute: Neonatal Programs**

* + Contact Naama Rozen (Naama.Rozen@cw.bc.ca) prior to submission of the PU Form for presentation at their departmental research rounds. She will assist with obtaining the necessary signatures.

 **Ambulatory Programs (including the Provincial Medical Genetics Program)**

* + Submit completed form and supporting documentation to the appropriate Program Manager as identified in the [Signatories List](http://www.phsa.ca/researcher/Documents/BCWH%20PU%20Form%20Signatories%20List.docx). If you have any questions about your submission, please contact Carola Muñoz (carola.munoz@cw.bc.ca).

**Section 5.1: Required Signatures (ACUTE PROGRAMS)** *For a full list of signatories, click* [*here*](http://www.phsa.ca/researcher/Documents/BCWH%20PU%20Form%20Signatories%20List.docx)

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| **Program Manager Signature**Add handwritten, scanned signature, or signature line in box below:

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| **Program Medical Lead Signature**Add handwritten, scanned signature or signature line in box below:

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| **Senior Director**Add handwritten, scanned signature or signature line in box below:

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| **Senior Medical Director**Add handwritten, scanned signature or signature line in box below:

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*\*Once Senior Director/Senior Medical Director signature is obtained, please submit to the office of the WHRI Executive Director (Rm H214 c/o Lori Brotto)*

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| **Executive Director, Women’s Health Research Institute Signature** Add handwritten, scanned signature or signature line in box below:

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| *For program use only. Notes/ Comments/Additional Information Required:* |

**Section 5.2.A: Required Signatures (AMBULATORY PROGRAMS)** *For a full list of signatories, click* [*here*](http://www.phsa.ca/researcher/Documents/BCWH%20PU%20Form%20Signatories%20List.docx)

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| **Program Manager Signature**Add handwritten, scanned signature, or signature line in box below:

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| **Program Medical Lead Signature**Add handwritten, scanned signature or signature line in box below:

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| **Senior Patient Services Director**Add handwritten, scanned signature or signature line in box below:

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| **Senior Medical Director**Add handwritten, scanned signature or signature line in box below:

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*\*Once Senior Director/Senior Medical Director signature is obtained, please submit to the office of the WHRI Executive Director (Rm H214 c/o Lori Brotto)*

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| **Executive Director, Women’s Health Research Institute Signature** Add handwritten, scanned signature, or signature line in box below:

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**Section 5.2.B: Required Signatures (Provincial Medical Genetics Program)***For a full list of signatories, click* [*here*](http://www.phsa.ca/researcher/Documents/BCWH%20PU%20Form%20Signatories%20List.docx)

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| **Program Operations Director Signature**Add handwritten, scanned signature, or signature line in box below:

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| **Program Medical Director Signature**Add handwritten, scanned signature or signature line in box below:

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| **Senior Medical Director**Add handwritten, scanned signature or signature line in box below:

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| **Chief Operating Officer, BC Women’s Hospital + Health Centre**Add handwritten, scanned signature or signature line in box below:

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*\*Once Senior Director/Senior Medical Director signature is obtained, please submit to the office of the WHRI Executive Director (Rm H214 c/o Lori Brotto)*

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| **Executive Director, Women’s Health Research Institute Signature** Add handwritten, scanned signature, or signature line in box below:

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