



UNIVERSITY HEALTH SYSTEM AUTHORIZATION FOR HUMAN RESEARCH EXEMPT FROM IRB REVIEW

All boxes on the proposal must be filled out. Place N/A on sections that do not apply.

				Date
Investigator (Name, Degree, Department, Provider Number)		Phone Number		Fax Number
E-mail Address				
Co-Investigator (Name, Degree, Department, Provider Number)		Phone Number		Fax Number
Study Coordinator		Phone Number		Fax Number
E-mail Address				
Protocol Title				
Short Title * Please limit to 24 characters				
Study Purpose * Please limit to 95 characters				
IRB Number	IRB Expiration Date	Projected Start Date In UHS Facilities	Projected End Date In UHS Facilities	Approx. # records requested

Check Type of Research: ___ Retrospective chart review & not recording identifying information,
 ___ Survey of Adults
 ___ Comparing Two Educational programs

I. Requested Institutional Support:

Project Site(s): (Check all boxes indicating where records will be reviewed or survey with be given)

- University Hospital
- University Health Center-Downtown
- University Center for Community Health
- University Family Health Center-Southwest
- University Family Health Center-Southeast
- University Family Health Center-North Central
- University Family Health Center-Northwest
- Correctional Health Care Services

Please list the year(s) of which records will need to be extracted from if Medical Records will be retrieving records for you.

II. Recruitment Strategies:

- Recruited from patients I am treating Written Authorization of patients
- Taken from a database that I maintain, will comply with HIPAA regulation on use and disclosure
- Who owns the database? _____
- Will submit a record request to Medical Records Department for patient listing
- OTHER: _____

III. Identification of Patients: (If more space is needed please attach)

- A. Have you/your research team identified patients/patient listing for the study? Yes No

- B. Will you be requesting a limited data set? Yes , If Yes, Please list information needed to perform your study. No

- C. List the contact person from your research team who will be responsible with submitting the disclosure log (will be required if a partial waiver or a waiver has been approved from the IRB)
Name _____ Phone Number _____ E-Mail _____

IV. Consent if applicable: Provide copies of IRB forms A-C, D-H and I-K as applicable

- A. Do you have a waiver for consent? Yes No
- B. Do you have an Information Sheet? Yes No
- C. Please provide a copy of the IRB approved consent form (if applicable)
If a Spanish translation is approved please provide a copy to the Research office as soon as possible
- D. The consent process **MUST** be documented in the medical record and a copy of the signed consent must be in the medical record.
** An information sheet is often permitted for studies involving interviews or questionnaires because these involve minimal risk and no physical procedures that could result in physical injury.*

V. Funding Source and Fund Administration:

Study funded by:	Charges to be applied to the following account:	
	UTHSCSA: _____ Department	OTHER:

- Budget Page:** Attached (Must be included with all funded submissions)
Federal Funded: Yes No
Grant Funded: Yes No If yes, Award Number for Grant: _____

Specify Address for Invoice: Local contact and address
(Local contact and Address) _____

VI. Support Services Information:

The following support services are requested for support of the study:

- Information Service (Access to Information Systems at UHS requested for Staff)
- Pt Business Service (Billing Information)

VII. Research Committee Oversight:

Abstract: Attached (Must be included-120 or fewer words, in any format)

VIII. Conflict of Interest Information:

Does the P.I. or co-P.I. disclose any potential conflicts of interest? Yes , submit IRB form X, No

Keywords: (minimum 3, maximum 6. use (Medical Subject Headings) terms only. Enter one term per line.)

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____
- 6) _____