

## Confirmation of Clinical Resources Form

Complete this form to request resources needed for your research study. Note: Researchers should utilize Clinical Research Center (CRC) resources whenever possible. Completion of this form does not guarantee availability/approval of resource(s). Additional orientation and other regulations may apply in the areas where research activities would take place. Justification for resources requested must be included. Use additional pages as needed.

**Instructions:** If you are requesting to use hospital (JDH or UMG) space and/or resources for your clinical trial, please complete the sections below. Send the completed form and the study protocol to Anne Horbatuck, Caryl Ryan, and respective chairs/center director or their designees to be routed for review and approval. The process should proceed in parallel with each step anticipated to be no more than 5 business days for a decision. to be routed for review and approval.

### PROGRAMMATIC DETERMINATION

Patient and research subject safety & compliance are our highest priority at UConn Health when conducting patient care including clinical trials. All trials—regardless of funding source—must comply with applicable regulatory policies. The designated space must be equipped appropriately for research activities, and meet the requirements within that space. In addition, adequate personnel, equipment, and procedures must be in place to respond to any unexpected adverse events. \* **Research personnel must be properly trained and, when required, certified for the procedures they perform.**

*Date of request:*

*Date and location of space where requesting this to take place:*

*Contact Phone:*

*Email:*

*Study title:*

*Phase:*

*Reviewing IRB:*

*IRB#:*

*Funding source:*

*Potential enrollment: Overall:*

*Annual:*

### **CLINICAL RESOURCES**

<b>TYPE OF RESOURCE / SPACE</b>	<b>DESCRIPTION AND JUSTIFICATION OF NEED / USE</b> (Include applicable quantity needed, length of hospital stay, clinic room /time, location and duration of room use, training required, time commitments, etc.)
Hospital Beds	<input type="checkbox"/> yes <input type="checkbox"/> no
JDH or UMG Exam Rooms	<input type="checkbox"/> yes <input type="checkbox"/> no
JDH or UMG Nursing; include training requirements	<input type="checkbox"/> yes <input type="checkbox"/> no
Use of JDH or UMG Equipment and/or supplies (e.g., ECG, Pyxis, Code Cart, etc.)	<input type="checkbox"/> yes <input type="checkbox"/> no
Specialized Equipment Needed (e.g. ophthalmology equipment, PFTs, infusion pumps, etc.)	<input type="checkbox"/> yes <input type="checkbox"/> no
Medication Administration include route	<input type="checkbox"/> yes <input type="checkbox"/> no
Requires Epic Order Set Build	<input type="checkbox"/> yes <input type="checkbox"/> no
Investigational Drug Services	<input type="checkbox"/> yes <input type="checkbox"/> no
Radiology Services	<input type="checkbox"/> yes <input type="checkbox"/> no
JDH Lab Services	<input type="checkbox"/> yes <input type="checkbox"/> no
Operating Room	<input type="checkbox"/> yes <input type="checkbox"/> no
Same Day Surgery	<input type="checkbox"/> yes <input type="checkbox"/> no
Other personnel to conduct special procedures	<input type="checkbox"/> yes <input type="checkbox"/> no
Other: _____	<input type="checkbox"/> yes <input type="checkbox"/> no

**Please provide any additional information to help us decide if the necessary clinical resources are available for the study:**

*Requesters Signature / Date:*

### **Determination and Signature of Hospital / UMG Administration**

Request approved, use of JDH/UMG space and/or resources requested above will be available for this research study.  
 Request not approved. For further resources and assistance, please refer to <https://health.uconn.edu/clinical-research-center/how-to-apply/>

*Signature of Approvers; Compliance*

*Regulatory*

*Caryl Ryan*

*Anne Horbatuck*

*Approve*

*Department Chair, Center Director*

*Dean (or Dean's Designee)*