Eastern Health

Process for Review and Approval of Research

In keeping with the commitment to review and to approve research projects in a timely and efficient manner, we have a two step research approval process.

1. All projects to be conducted within the organization are required to have review and full approval of the Health Research Ethics Board. Information on the Health Research Ethics Board application forms and process are available from web site http://www.hrea.ca

2. Once full approval has been granted by HREB, application for research to be conducted within the organization must be made to the Research Proposal Approval Committee (RPAC). The primary mandate of this committee is to review resource utilization, impact to the organization and access to confidential information for any project to be conducted within the organization.

Prior to receiving final approval, all projects will require:

- Review by the appropriate Clinical Chair or Director.
- Notification to the management of the department/program/service where the research will be conducted.
- Completion of departmental agreements, as necessary.

The Committee meets on the second Tuesday of each month. **Application must be received one week before each meeting.** Incomplete applications may delay approval of the proposal.

The following documentation is required to complete your application:

- ☐ **A scanned/faxed/or original copy of the RPAC application signed by the Principal Investigator and the Clinical Chief / Department or Program Manager/Director**
- ☐ **An electronic copy of the RPAC application**
- ☐ **HREB application and approval letter**
- ☐ **Budget**
- ☐ **Departmental agreements (as necessary)**

Please forward the RPAC application and required documents to:

Manager, Clinical Research
Room 534, 5th Floor, Janeway Hostel
300 Prince Philip Drive, St. John's, NL
A1B 3V6
Telephone: (709) 777-7283 **Fax:** (709) 752-3591

Email: RPAC@easternhealth.ca

Eastern Health

RPAC Application

(Page 1)

HREB Reference Number: _____

Protocol Title and Number:

Sponsor / Source of funding: _____

Principal Investigator: _____

Key Contact Name: _____

Telephone number: _____ **Email:** _____

Address: _____

Anticipated Number of Participants (if applicable): _____

Study Objectives:

Study Description:

TESTS and PROCEDURES

Does the proposal involve local laboratory tests, x-rays or other imaging techniques other than those required for normal patient care? If yes, please attach a Departmental Agreement.	**YES** **NO**
Will samples be sent to a central laboratory?	**YES** **NO**
Does this project request use of archived biological samples?	**YES** **NO**

Eastern Health

RPAC Application
(Page 2)

PHARMACY

Does this proposal involve the use of study medication (including placebos) that will be dispensed by the Hospital Pharmacy? ☐ **YES** ☐ **NO**

If yes, please specify and attach a Departmental Agreement:

HEALTH RECORDS or HDTM

Does this project require access to Health Records or HTDM? ☐ **YES** ☐ **NO**
(Healthcare Technology and Data Management)

If yes, how many records? _____ **Paper** ☐ **YES** ☐ **NO** **Electronic** ☐ **YES** ☐ **NO**

When do you plan to do this review? _____

OTHER HOSPITAL SUPPORTS

Does the proposal require assistance of nurses or hospital staff other than research personnel? ☐ **YES** ☐ **NO**

If yes, please describe:

Does the proposal involve admission of subjects to the hospital or a clinical investigation unit? ☐ **YES** ☐ **NO**
If yes, please describe:

All projects require a notification to the management of the department/program/service where the research will be conducted.

Please indicate the name of the person notified:

Date Notified:

The approval of this proposal is contingent upon:

- Adequate funding being available to support the project
- The researcher providing an update on the progress of the research project upon request

Your signature on this form gives approval to list your project in our annual report.

_____ DD/MONTH/YYYY
Name of Principal Investigator Date

_____
Signature of Principal Investigator

_____ DD/MONTH/YYYY
Name of Manager/Director/Clinical Chief Date

_____
Signature of Manager/Director/Clinical Chief