



Departmental Agreement Department of Research and Innovation (Part I)



All requests for Departmental Agreements (DA) are sent to the **Manager, Clinical Research**. Please provide a copy of the research protocol with your request. It will take between 2-6 weeks to determine pricing/budgetary considerations for a DA. To ensure efficient and accurate service, applicable fields must be completed in full. Incomplete submissions will be returned to the Principal Investigator. **For Medical Imaging DA, please complete Section 1 and Part II. For all other Agreements, please complete Part 1 only. If more than one service is required, please complete a separate DA for each service.**

Section 1: To be completed by Principal Investigator or Designate

Principal Investigator:	
Study/Site Coordinator: Name: _____ Telephone: _____ Email: _____	
HREB Reference Number:	
Short Title of Study:	
Research Type: <input type="checkbox"/> Private/Industry Sponsored <input type="checkbox"/> Academic/Non-industry Sponsored	
Anticipated Start Date of Service: DD/MONTH/YYYY Anticipated End Date of Service: DD/MONTH/YYYY	
Program Impacted:	
Service/Procedure Requested:	
Number of Patients or Procedures projected:	
Participating Sites: <input type="checkbox"/> HSC <input type="checkbox"/> Janeway <input type="checkbox"/> SCM <input type="checkbox"/> Other (<i>specify</i>):	

Please note - All costs will be the responsibility of the study. Billing is based on a cost recovery basis so services are billed at the appropriate real time rate. Annual increases will be applied, as required.

Principal Investigator's Name: _____ Date: _____ DD/MONTH/YYYY
Principal Investigator's Signature: _____

Section 2: To be completed by applicable Eastern Health Program Director or Designate

Service Requested	Number of Patients/Procedures projected	Base Fee for Service (if applicable)	Other Fees	Total Cost of Service
Total Estimated Cost		\$		

Program Director's Name: _____ Date: _____ DD/MONTH/YYYY

Program Director's Signature: _____

DEPARTMENT of RESEARCH and INNOVATION

Name: _____ Date: _____ DD/MONTH/YYYY

Signature: _____



Departmental Agreement Department of Research and Innovation (Part II)



Medical Imaging Requirements: Include all examinations required throughout the study timeline. **Check all that apply.**

Modality(s) Required: <input type="checkbox"/> CT <input type="checkbox"/> MRI <input type="checkbox"/> PET <input type="checkbox"/> X-Ray <input type="checkbox"/> Ultrasound <input type="checkbox"/> Bone Density <input type="checkbox"/> Mammography
Anatomy Requirements (<i>please specify</i>):
Interpretation Requirements (check one only): <input type="checkbox"/> Radiologist (full) <input type="checkbox"/> Radiologist (diagnosis confirmation) <input type="checkbox"/> No imaging interpretation required
Data Management and Transmission: <input type="checkbox"/> Image Encryption prior to Transmission <input type="checkbox"/> Removal of Participant Identifiers <input type="checkbox"/> CD <input type="checkbox"/> USB Flash Drive <input type="checkbox"/> Web Transmission <input type="checkbox"/> Other (<i>specify</i>): _____

Funding Requirements (*To be completed in consultation with Medical Imaging*)

Estimated Exam Volume	Examination Required	Interpretation Required (Yes / No)	Technical Fee	Professional Fee	Other fees	Total Cost per Exam
		<input type="checkbox"/> Yes <input type="checkbox"/> No				
		<input type="checkbox"/> Yes <input type="checkbox"/> No				
		<input type="checkbox"/> Yes <input type="checkbox"/> No				
Total Estimated Cost						\$

Additional Funding/Training/Staffing Requirements:

Final Agreement Checklist

- Study Protocol sent/attached
- Medical Imaging Protocol including imaging requirements and technical parameters approved
- Education and/or training requirements by imaging staff specified, reviewed and approved
- Data management and transmission specified, reviewed and approved
- Funding requirements specified, reviewed and approved

Program Director's Name: _____

Date: DD/MONTH/YYYY

Program Director's Signature: _____

Principal Investigator's Name: _____

Date: DD/MONTH/YYYY

Principal Investigator's Signature: _____