



# 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/evaluation 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 I 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/Project Coordinator's Name: _____ Telephone: _____ Email: _____	
HREB Reference Number (if applicable):	
Short Title of Study/Project:	
Research/Project 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 (specify):	

**Please note - All costs will be the responsibility of the study/project. Billing is based on a 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
<b>Total Estimated Cost</b>		<b>\$</b>		

Program Director's Name: \_\_\_\_\_ Date: DD/MONTH/YYYY  
Program Director's Signature: \_\_\_\_\_

**Department of Research and Innovation**

Name: \_\_\_\_\_ Date: DD/MONTH/YYYY  
Signature: \_\_\_\_\_



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

<b>Modality(s) Required:</b> <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
<b>Anatomy Requirements (please specify):</b>  
<b>Interpretation Requirements (check one only):</b> <input type="checkbox"/> Radiologist (full) <input type="checkbox"/> Radiologist (diagnosis confirmation) <input type="checkbox"/> No imaging interpretation required
<b>Data Management and Transmission:</b> <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 (specify): _____

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

Estimated Exam Volume	Examination Required	Interpretation Required	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				
<b>Total Estimated Cost</b>						<b>\$</b>

**Additional Funding/Training/Staffing Requirements:**

**Final Agreement Checklist**

- Study/Project 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: \_\_\_\_\_