Departmental Agreement
Department of Research and Innovation
(Part I)

NC1120 2107 01 2020

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: ☐ Private/Industry Sponsored ☐ 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: ☐ HSC ☐ Janeway ☐ SCM ☐ 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
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: _____

Eastern Health

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

Modality(s) Required: ☐ CT ☐ MRI ☐ PET ☐ X-Ray ☐ Ultrasound ☐ Bone Density ☐ Mammography

Anatomy Requirements *(please specify):*

Interpretation Requirements (check one only):
☐ Radiologist (full) ☐ Radiologist (diagnosis confirmation) ☐ No imaging interpretation required

Data Management and Transmission:
☐ Image Encryption prior to Transmission
☐ Removal of Participant Identifiers
☐ CD ☐ USB Flash Drive ☐ Web Transmission
☐ 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
		☐Yes ☐No				0.00
		☐Yes ☐No				0.00
		☐Yes ☐No				0.00
				Total Estimated Cost		$ 0.00

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: _____