

The University of Alabama  
College of Community Health Sciences  
**Request to Conduct Research**

All research projects conducted at University Medical Center (UMC), Student Health Center (SHC) or Warrior Family Medicine (WFM) must be approved by the College of Community Health Sciences' Associate Dean for Research & Health Policy prior to the initiation of the study. This document confirms that the researcher has coordinated efforts with UMC/SHC faculty and staff and that a CCHS faculty member is part of the research project. **After your research project has received IRB approval, a copy of the stamped cover page of you IRB proposal prior to the implementation of your project is required.** For full details, refer to CCHS' website, <http://cchs.ua.edu/research/request-to-conduct-research>. Questions/contact: **John C. Higginbotham, PhD, MPH**, Associate Dean for Research & Health Policy, [jhiggin@cchs.ua.edu](mailto:jhiggin@cchs.ua.edu).

Type requested information below, print, obtain appropriate signatures & submit all information to: Barbara Wright, IRHR, Box 870326 (B111 UMC), [bwright@cchs.ua.edu](mailto:bwright@cchs.ua.edu).

**PROJECT INFORMATION**

Location:                      University Medical Center (UMC)                      Student Health Center (SHC)                      UMC & SHC                      Warrior Family Medicine (WFM)

Principal Investigator (PI): \_\_\_\_\_ Title: \_\_\_\_\_

College: \_\_\_\_\_ Dept/Center: \_\_\_\_\_ Campus Box # 870\_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_

Proposal Title: \_\_\_\_\_

Project Period: \_\_\_\_\_ to \_\_\_\_\_

Brief Summary (for full details, refer to CCHS' website (link listed above))

List HIPAA and Ethics training dates, & attach certificates:

PI, Sub-investigator(s), collaborators	HIPAA	Ethics training	PI, Sub-investigator(s), collaborators	HIPAA	Ethics training
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

EHR (Electronic Health Record) Access Required:    Yes    No    If Yes, list who will need access and explain why:

**APPROVALS**

**Faculty Collaborator** – A CCHS Faculty Collaborator is required if you are a student or faculty outside of CCHS.

*I have reviewed the proposal and endorse it with respect to the technical quality, appropriateness, and compatibility with UMC/SHC and the CCHS established protocols and procedures.*

\_\_\_\_\_  
Collaborator Name (typed)                      Collaborator signature                      Date

**Clinic(s) involved**

<u>Clinic</u>	<u>Clinic Director signatures</u>	<u>Date</u>	<u>Department Chair signatures</u>	<u>Date</u>
Faculty/Staff	_____	_____	_____	_____
Family Medicine	_____	_____	_____	_____
Internal Medicine	_____	_____	_____	_____
OB/GYN	_____	_____	_____	_____
Pediatrics	_____	_____	_____	_____
Psychiatry	_____	_____	_____	_____
Student Health Center	_____	_____	_____	_____
Warrior Family Medicine	_____	_____	_____	_____

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**Clinic - Study Requirements**

1<sup>st</sup> Clinic: \_\_\_\_\_ Explain below.

- Select all that apply:
- Billing/Coding Issues
  - Staff Support
  - N/A Financial Assistance
  - Supplies
  - Space
  - None

Clinic Director/Dept Chair Comments:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2nd Clinic: \_\_\_\_\_ Explain below.

- Select all that apply:
- Billing/Coding Issues
  - Staff Support
  - N/A Financial Assistance
  - Supplies
  - Space
  - None

Clinic Director/Dept Chair Comments:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Lab / X-Ray**

Explain below.

- Select all that apply:
- Billing/Coding Issues
  - Staff Support
  - N/A Financial Assistance
  - Supplies
  - Space
  - None

Director Comments:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Director Signature: Tina Conn Date

**Medical Records**

Explain below.

- Select all that apply:
- Billing/Coding Issues
  - Staff Support
  - N/A Financial Assistance
  - Supplies
  - Space
  - None

Director Comments:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Director Signature: Jan Chaisson Date

**EHR Access/HIPAA Privacy**

Explain below.

- Select all that apply:
- Billing/Coding Issues
  - Staff Support
  - N/A Financial Assistance
  - Supplies
  - Space
  - None

Director Comments:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Director Signature: Amy Sherwood Date

**Financial** CFO Comments:

N/A \_\_\_\_\_  
\_\_\_\_\_  
Allison Arendale, Director of Finance Date

**Operational** COO Comments:

N/A \_\_\_\_\_  
\_\_\_\_\_  
David Nichols, Chief Operating Officer Date

**IRHR use only: Associate Dean for Research & Health Policy**

EHR Access Approved: (Present the documentation of EHR access to Ann King)

Approved:  Yes  No  N/A  Yes  No

John C. Higginbotham, PhD, MPH date

Dean's Comments: \_\_\_\_\_  
\_\_\_\_\_

Barbara Wright, Program Assistant/IRHR