

**THE UNIVERSITY OF ALABAMA
SCHOOL OF MEDICINE, TUSCALOOSA CAMPUS
REQUEST TO CONDUCT RESEARCH AT UMC
INTERNAL COORDINATION SHEET**

Date Received _____

PROJECT INFORMATION

Proposal Title _____

Project Period: _____ to _____

Project Director/Principal Investigator _____

Title _____

Phone _____ Fax _____ Email _____

College _____ Department/Center _____

List your sub investigators and collaborators and give HIPAA and Ethics training dates for each:

HIPAA Training completed (Date): _____ (please attach your certificate)

Ethics Training completed (Date): _____ (please attach your certificate)

EMR Access Required ____ Yes ____ No

If Yes, list who will need access and explain why: _____

APPROVALS

I have reviewed the proposal and endorse it with respect to the technical quality, appropriateness, and compatibility with the University Medical Center and the College of Community Health Sciences (CCHS) established protocols and procedures.

CCHS Faculty Collaborator Name: _____

CCHS Faculty Collaborator (signature, if approved)

Date

Department Name: _____

Clinic Name: _____

Investigator: Briefly list expectations for each department/clinic.

Study Requirements of Dept/Clinic:

Time in Clinic: _____

Staff support: _____

Financial assistance: _____

Supplies: _____

Space: _____

Department/Clinic Comments:

Department Chair (signature, and have met with investigator and approved)

Date

Clinic Director (signature, if approved)

Date

If Applicable:

Department Name: _____

Clinic Name: _____

Study Requirements of Dept./Clinic:

Time in Clinic: _____

Staff support: _____

Financial assistance: _____

Supplies: _____

Space: _____

Department/Clinic Comments:

Department Chair (signature, if approved)

Date

Clinic Director (signature, if approved)

Date

If Applicable:

Department Name: _____

Clinic Name: _____

Study Requirements of Dept./Clinic:

Time in Clinic: _____

Staff support: _____

Financial assistance: _____

Supplies: _____

Space: _____

Department/Clinic Comments:

Department Chair (signature, if approved)

Date

Clinic Director (signature, if approved)

Date

Laboratory and X-Ray

Study Requirements of Department:

Time in Lab/X-Ray: _____

Staff support: _____

Financial assistance: _____

Supplies: _____

Space: _____

Director Comments:

Sherry Wedgeworth; Director of Lab and X-ray (signature, if approved)

Date

Medical Records/HIPAA Privacy/EMR Access

Study Requirements of Department:

Time in department: _____

Staff support: _____

Financial assistance: _____

Supplies: _____

Space: _____

Director Comments:

Jan Chaisson; Medical Records Director (signature, if approved)

Date

Billing and Coding Compliance/HIPAA Security

Study Requirements of Department:

Time in Department: _____

Staff support: _____

Supplies: _____

Space: _____

Director Comments:

Michael Greene, Director,
Billing and Coding Compliance (signature, if approved)

Date

Financial

COO/CFO Comments:

Allison Arendale, Director of Finance (signature, if approved)

Date

Amelia De Los Reyes, Director of Clinical Operations (signature, if approved)

Date

Research Dean

Research Dean's Comments:

John C. Higginbotham, Ph.D., MPH
Associate Dean for Research and Health Policy (signature, if approved)

Date

Sandy Bennett, Administrative Secretary
Division of Clinical Investigations

Date

EMR Access Approved

John C. Higginbotham, Ph.D., M.P.H.

Please present the documentation of EMR access to Ann King or Amelia De Los Reyes

Dr. Higginbotham's signature confirms approval to conduct research at University Medical Center.
It does not confirm approval from The University of Alabama's Institutional Review Board.