**Western Michigan University Homer Stryker M.D. School of Medicine
Institutional Assurance and Approval of Proposed Study**

These forms are for studies that do not involve a grant or contract overseen by WMed. Studies that involve a grant or contract overseen by WMed must be routed through WMed Sponsored Programs Administration.

Proposed Principal Investigator: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Protocol Attached: [ ]

Study Synopsis:

*For example: This is a [Phase XX or other appropriate description] study, which will investigate [insert summary here]*.

The following supportive services are required to conduct this study:

[ ]  Laboratory Contact:

[ ]  Pharmacy Contact:

[ ]  Imaging Contact:

[ ]  Nursing Contact:

[ ]  Medical Records Contact:

[ ]  Information Technology (IT) Contact:

[ ]  Other Ancillary Service(s) Contact:

[ ]  Study Location(s) Contact:

If this study uses WMed student, resident/fellow, or faculty data (surveys, opinions, academic information, etc), the following approval(s) is required.

[ ]  Student Data: Date: Associate Dean for Educational Affairs

[ ]  Resident/Fellow Data:  Date:
 Associate Dean for Graduate Medical Education

[ ]  Faculty Data: Date: Associate Dean for Faculty Affairs

If WMed services are necessary to complete the proposed study (as indicated above), services approval needs to be obtained prior to IRB review. A services approval form (page 2) is attached that may be used for each of the services at WMed that will provide services for this study. Once each services review is completed, submit this form and all services approval forms to the department chair for approval.

**Services Approval**

The information being provided is governed by a Confidential Disclosure Agreement, which permits seeking your input but prohibits sharing this information beyond the extent required to complete this assessment.

Services:

Reviewer:

Comments:

Recommendation: APPROVE [ ]  REJECT [ ]

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: ­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Department Approval
Departmental Chair Assurance and Approval of Proposed Study**

I have reviewed the proposed study and approve this study to be conducted at WMed. The named investigators are qualified and possess the necessary credentials to conduct the research and perform the required protocol procedures. WMed will ensure that the investigators have access to adequate facilities, time, staff, and equipment to perform the study, and that emergency care will be available or arranged should the need arise.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: ­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Department Chair

**Western Michigan University Homer Stryker M.D. School of Medicine
Institutional Assurance and Approval of Proposed Study**

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: ­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Associate Dean for Research