

**Institutional Assurance and Approval of Proposed Study**

**at WMed Affiliated Institutions**

**Study Title:**

This form is for studies for which the WMed IRB either is the IRB of record or has waived oversight to an external IRB and which also use resources, services, or patients at       (“Institution.”)

If the study involves a grant or contract overseen by WMed, please contact the director of Sponsored Programs Administration to complete a sponsored programs administration Institutional Assurance and Approval form.

Proposed Principal Investigator:

Protocol or Synopsis Attached:

Brief Description of Study:

If Institution services are necessary to complete the proposed study, services approval needs to be obtained prior to Institutional Approval. Once each services review is complete, submit this signed form and all services approval documentation to the Chief Medical Officer or other authorized Institutional signatory for final approval.

The following services at the Institution are required to conduct this study:

*Signature or email correspondence is required as evidence of approval for each service.*

Laboratory: Date:

Pharmacy: Date:

Imaging: Date:

Nursing: Date:

Medical Records: Date:

Information Technology (IT): Date:

Other Ancillary Service(s): Date:

Study Location(s):  Date:

Does this study use any WMed student, resident/fellow, or faculty data (surveys, opinions, academic information, etc.)? No  Yes  If Yes, WMed institutional approval is required.



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I have reviewed the proposed study and approve this study to be conducted at the Institution*.* The named investigators are qualified and possess the necessary credentials to conduct the research and perform the required protocol procedures. The Institutionensures 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: ­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
 Authorized Institutional Official

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_