

Clinical and Molecular Epidemiology Shared Resource (CMESR) Investigator Service Request

GU Non-GU Request # _____

Name: _____ Academic Rank: _____

Department: _____ Address: _____

Telephone: _____ Fax: _____

Email: _____

Project Title: _____

IRB Approval Received? Yes Approval #: _____ No Application Date: _____

Are samples or data to be used for funded research? Yes No If yes: Funding Agency: _____

Grant #: _____ Principle Investigator: _____

Your budget number (RX, GX etc...) _____

For each type of sample needed, provide the following information:

Sample Type (e.g : Serum, Plasma, DNA Extracts)	Patient Type	Sample Number	Data Required (Smoking, Hormone exposure, diet, demographics etc...)
	Control, Normal Risk		
	Cancer, Before Treatment		
	Cancer with Recurrence		
	Cancer During Specific Treatment		

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We provide the samples in sterile Eppendorf tubes in 100ul aliquots on dry ice. Please indicate if a different volume is needed or if there are special handling instructions:

Special Handling/Volumes:
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Important: For large sample requests it not always possible to retrieve all samples on the same day.

Please enter the contact information for the person that will come to pick up the samples:

Contact Name:	Phone:
Email:	

Describe the study and the intended use of the samples/data: Indicate how the sample size was determined and if biostatistical consultation was obtained:

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Review, sign and attach the "IRB Certificate for Repository Use". A copy of the repository's protocol is available upon request.

You must have proof of current Human Subject Protection Training. Please send your certificates along with this application.

<http://www9.georgetown.edu/gumc/ora/irb/irbTraining.htm> (every 3 years)

<http://mri.medstar.net/departments/ora/HIPAA/hipaatest.htm> (one time)

In accepting these samples, I agree that their use will be restricted to testing as described in the study description above, and not for any other purpose.

Signature: _____ date: _____

For oversight committee use: <input type="checkbox"/> approved <input type="checkbox"/> rejected Reason for rejection: _____ Director's signature: _____ date: _____
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IRB CERTIFICATE FOR REPOSITORY TISSUE USE

To: Biomarker Shared Resource, LCC

Re: Certification for use of serum/plasma/tissue and/or data from the repository

I, _____(name), acknowledge that the conditions for use of this research material are governed by the repository's Institutional Review Board (IRB) in accordance with Department of Health and Human Services regulations 45 CFR 46. I agree to comply fully with all such conditions. I understand that the data and/or specimens will be coded to protect the confidentiality of the donors of these materials. I have reviewed the repository's IRB protocol and I agree that (check one box):

I have reviewed the repository's consent form.

This research material will only be utilized in accordance with the conditions stipulated by the repository IRB protocol. I will not perform any assays or use tissues or any other repository resource for a purpose that is not approved by the IRB. I do not need an IRB approval for my specific project. In brief, my project will use repository material for the following:

This research material will be utilized for studies that are not covered under the repository's IRB protocol. I have received prior IRB review and approval for my studies and a copy of the approval letter is attached. In brief, my project will use repository material for the following:

I agree to report promptly to the repository any proposed changes in the research project. I remain subject to applicable State and local laws or regulations and institutional policies, which provide additional protections for human subjects.

(Signed)

(Date)

(Printed Name)