

SAPCRen Project Request Form

Primary Investigator Name: Email: Institution/Organization:	
Name of Co-Investigators Please indicate primary care providers with an asterisk (*):	
Project Title:	
Location(s) where the research will be conducted:	
Has this project been funded already? If yes , funding agency: If no , what are the potential funding sources:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Is there industrial funding and/or any commercial involvement? If yes , describe:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Has this project undergone scientific peer-review? If yes , describe:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Has this study received REB approval? If yes , provide REB approval number:	Yes <input type="checkbox"/> No <input type="checkbox"/>

Research question(s) and rationale for doing the study; how is this relevant/important to primary care?

Budget and justification:
<p>SAPCReN involvement in the project (if support is requested):</p> <p>How many practices/offices to recruit:</p> <p>How many patients to be recruited (if applicable):</p> <p>Over what time period:</p> <p>Overall request for facilitator hours, data analyst time, and/or any other support:</p>
<p>Signature of investigator attesting that:</p> <ol style="list-style-type: none"> 1. I have read the SACPRen Study Guidelines. 2. All data provided by SAPCReN-CPCSSN will be held in the highest confidentiality and will not be used or disclosed for any purpose other than the above-listed project; <i>and</i> 3. Administrative, physical, and technical safeguards will be in place to prevent use or disclosure of SAPCReN-CPCSSN data other than agreed to for the above-mentioned project. <p>Signature of Primary Investigator: _____ Date: _____</p> <p>Signature of SAPCReN Director: _____ Date: _____</p>

Please email completed form to info@sapcren.ca