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| Submit typed, hard copy of this form with **original signatures** for review. **\*\*Keep a copy for your files\*\*** | | | | |
| **SECTION 1a** | **Study Title** | | | |
| Study Title: |  | | | |
| **SECTION 1b** | **Principal Investigator** *(Must be a MSH Staff Member)* | | | |
| Name: | Division/Department: | | | Program: |
| Address (Room Number): | Telephone: | | | Fax/Email: |
| **SECTION 1c** | **Co-Investigators(s)** | | | |
| Name: | Division/Department: | | | Program: |
| Address (Room Number): | Telephone: | | | Fax/Email: |
| **SECTION 1d** | **Person(s) who will perform the experiment** *(include as many persons as necessary)* | | | |
| Name: | Division/Department: | | | Program: |
| Address(Room Number): | Telephone: | | | Fax/Email: |
| **SECTION 1e** | **Person (s) who will access retrospective patient data if applicable** *(include as many persons as necessary)* | | | |
| Name: | Division/Department: | | | Program: |
| Address (Room Number): | Telephone: | | | Fax/Email: |
| **SECTION 1f** | **Agreements** | | | |
| **Confidentiality Agreement**  I, the undersigned, agree to adhere to the **MSH Policy on Information and Data Security (Policy #I-H-5)** and understand that a breach of this policy will be just cause for termination of my employment and/or affiliation with the hospital. I agree that all health information, which I may have access to, is to be dealt with in keeping with the policies and procedures of Mount Sinai Hospital with respect to confidentiality. If identifying information is collected, the information will be kept secure and identifiers removed at the completion of collection. I also accept full responsibility for protection of information that has been collected by a delegate on my behalf. | | | | |
| Principal Investigator Signature: | | Print Name: | Date (dd/mmm/yyyy): | |
| Signature of Individual(s) Accessing Retrospective Data if applicable (if not PI): | | Print Name: | Date (dd/mmm/yyyy): | |
| **Division/Department Approval**  I have reviewed this proposal and agree that the proposed use of human tissue materials in the project represents appropriate use of the human tissues available for research. | | | | |
| Division/Dept. Head Signature: | | Print Name: | Date (dd/mmm/yyyy): | |
| **Pathology & Lab Medicine Departmental/Division Representative** *(please complete if this study will have an impact on Pathology & Lab Medicine)*  *Pathology & Lab Medicine Contact: Maria Mendes, ext. 7551*  I have reviewed the proposal and agree that appropriate human tissue materials are available for this study. | | | | |
| Pathology & Lab Medicine Representative Signature: | | Print Name: | Date (dd/mmm/yyyy): | |

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| **SECTION 2** | **Study Details** | | | |
| **Time Frame:** | | | Proposed Start Date (dd/mmm/yyyy): | Termination Date (dd/mmm/yyyy): |
| **How will the study be funded?**  Grant – Specify funding source:  Industry – Sponsor:Provide Name & full billing address including a contact’s name & email address:  Internal – Specify funding source:  No Funding Required | | | | |
| **Tissue Source** | | Archived Fixed Tissue | | |
| Frozen Tumour Bank  Specify Bank: | | |
| Autopsy | | |
| Fetal | | |
| Fresh Tissue  Obtained from:  Surgical Specimen  Excess Blood Sample  Excess Body Fluid | | |
| Other  Please specify: | | |
| **Consent Attached?** (Include consent to be used with application, if applicable). | | Yes  No | | |
| **Does the study involve genetic research?** | | Yes  No  If yes, please provide details: | | |

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| **SECTION 3** | **Research Proposal for the Study of Human Tissue** | |
| 1. Primary objective and hypothesis of the study: | |  |
| 1. Indicate the approximate number of tissue samples that will be required for this study. | |  |
| 1. How will the tissue be identified? | |  |
| 1. Will any identifying information be recorded? | | Yes  No  If yes, please specify the identifying information and justify the necessity for its collection: |
| 1. Will the individual identifiers be removed once the relevant data is collected? | | Yes  No  If no, please justify: |
| 1. How will security and confidentiality of the data be ensured? | |  |
| 1. Is there any anticipated linkage of the data to be collected with a clinical database? | |  |
| 1. Will the data be available or distributed to others? | | Yes  No  If yes, specify how confidentiality will be protected: |
| 1. Will the data being collected be used now or in the future for commercial purposes? | | Yes  No  N/A  If yes, please provide details: |
| 1. Will the tissue be sent to another facility for study? | | Yes  No  If yes, please name the location and provide the REB approval letter of the institution:    If yes, is there a Material Transfer Agreement:  Yes  No  Pending |
| 1. \*\*Attached summary: | | \*\* Attach a brief summary of the research project (1 page maximum) or the summary page of the grant proposal. |

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| **SECTION 4** | **Request to Access Retrospective Data for Research Purposes**  *Please indicate if this section is not applicable (N/A) to your study* | | | |
| 1. Data source: Identify all sources of data   In Patient  Day Surgery  Emergency  Database (Specify: ) | | | | |
| 1. Specify the data to be collected or attach data collection form. | |  | | |
| 1. Proposed number of research subjects/charts: | |  | | |
| 1. Time period of requested data: | | From  (dd/mmm/yyyy): | To  (dd/mmm/yyyy): | |
| 1. If personal health information is collected, used or disclosed, without consent from individuals to whom the information relates, explain why obtaining explicit consent would be impractical. | |  | | |
| 1. How will relevant patient charts be identified? | |  | | |
| 1. Have you already developed a list of specific patients? | | Yes  No  If Yes, please indicate how patients were identified: | | |
| 1. Will any identifying information be recorded? 🞏 YES 🞏 NO | | Yes  No | | |
| If yes**:**  i) Specify the identifying information and justify the necessity for its collection. | | ii) Will individual identifiers be removed once the relevant data is collected? If not, please justify. |
| 1. Will this data be transferred outside of MSH? | | Yes  No  If yes, where**:**  Is there a Data Sharing Agreement:  Yes  No  Pending  How will the confidentiality be protected? | | |
| 1. Is this a multi-centre study? | | Yes  No  If yes, please identify the other sites and indicate the REB approval status: | | |
| 1. Is there any anticipated linkage of the data to be collected with other data? | | Yes  No  If yes, how will the linkage information be treated? | | |
| 1. Will this data be reported publicly? (e.g. publication) | | Yes  No | | |
| 1. Will this data being collected be used now or in the future for commercial purposes? | | Yes  No  If yes, please provide details: | | |
| 1. How will security and confidentiality of the data be protected, maintained and retained? | |  | | |