APeX New Clinical Trial Study Request Form

December 2018 version

Note to Study Teams: *Please submit completed form to the Office of Clinical Research at* ***clinicaltrials@ucsf.edu*** *for processing. Do not submit directly to the APeX team.*

Study Name, beginning with ZZxxxx, Study:
Maximum length is 25 characters

Study Description:
Full Study Title

CHR # / CAR # (Study Code):

Chart of Accounts (COA):
Dept ID (6-digits) - Fund (4-digits) - Function (2-digits) - Project (7-digits) - Activity Period (2-digits)
Please make sure you follow the above format for your COA*; consult with your Financial Manager for this info*

National Clinical Trial # (NCT#):
This must be included if your study qualifies for an NCT#. If it does not, please enter NCT99999999. Do not leave blank. You can visit www.clinicaltrials.gov to see if you qualify

Funding Source and CRB Status fields will be completed by the Office of Clinical Research Intake Team

Funding Source:

CRB Status:

Does this study involve clinical research billing? **Choose from list**

If non-CRB, who approved as non-CRB? **Choose from list**

Date approved as non-CRB: mm/dd/yyyy

Reason study is designated non-CRB: **Choose from list**

Department
This should be the home department of the Principal Investigator

- ◯ Anesthesia and Pain Management
- ◯ Dermatology
- ◯ LPPI
- ◯ Medicine excluding Hematology/Oncology
- ◯ Medicine Hematology/Oncology
- ◯ Neurologic Surgery
- ◯ Neurology
- ◯ Obstetrics and Gynecology
- ◯ Ophthalmology
- ◯ Orthopedic Surgery
- ◯ Osher Center for Integrative Medicine
- ◯ Otolaryngology
- ◯ Pediatrics
- ◯ Radiology
- ◯ Radiation Oncology
- ◯ Surgery
- ◯ Urology
- ◯ Proctor Foundation
- ◯ Other _____

Key Contact Name:
This is the person who will receive your MONTHLY Research Statements

_____

Key Contact Address:
Address, City, State, Zip

_____

Key Contact phone number:

_____

Principal Investigator Name and APeX ID:
(e.g. Gregory House, MD 61175)

_____

Primary CRC Name:
This should be the main contact for the study and/or the CRC responsible for billing review.

_____

Other CRCs Name(s):
Please list any other CRCs related to this study.

Nurse(s) Name(s) and ID(s):

Co-investigator(s) and ID(s):

Clinical Trial?

- ◯ Yes
- ◯ No

Device Trial?

- ◯ Yes
- ◯ No

Charge Reviewer Assigned:
(Internal Use Only)