

Clinical Trial Collaboration Request Form

Please complete the form in as much detail as possible. Items can be left blank if you are not able to provide answers.

Date of Request:

1. PRINCIPAL INVESTIGATOR/KEY CONTACT

PI Name:	
Institution:	
Email Address:	
Co-Investigators/Collaborators: (if applicable)	

2. STUDY DESIGN

Study Title:	
Short Title/Acronym:	
Study Phase/Design:	
Study Objective:	
Patient Population:	
Estimated Sample Size:	
Randomization:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Study Intervention/Control: Investigational Product/Device:	
Treatment Schedule:	
Is Regulatory Approval required?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure
Correlative Studies:	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure

3. FEASIBILITY / TIMELINES

Estimated Number of Clinical Sites:	
Planned Countries:	
Estimated Accrual per Month:	
Clinical Trial Duration: (number of years)	
Recruitment Duration:	
Follow-up Duration:	
Anticipated Start Date:	

4. STUDY RATIONAL and OBJECTIVES

Provide a brief summary of the research question including relevant background information, patient population, primary and secondary objectives and outcomes, including safety reporting requirements. If you have conducted a feasibility or pilot study to inform a trial, please provide brief details.

5. FUNDING STATUS	
Estimated Trial Cost (<i>if known</i>):	
Granting Agency:	
Grant Submission Deadline:	
Industry Funding/Support:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Industry Partner (<i>if applicable</i>):	
Industry Partner Deadline (<i>if applicable</i>):	
In the event funding has already been received, provide details:	
6. LIST ANY OTHER SOURCES OF SUPPORT /RESOURCES (drug supply, equipment provision etc.)	
7. ADDITIONAL COMMENTS	