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| **Purpose:**  This appendix is designed to provide information to the IRB for human subjects research involving the use of ionizing radiation. |

**Instructions:**

* Complete only if your research activities will include the use of ionizing radiation.
* Respond to every question on this application. Incomplete applications will be returned, and will result in a delay of your study being reviewed. If a question does not apply, answer N/A. Do not leave any question blank.
* This appendix is a part of the Research Plan and must be included with each Research Plan submission.
* Save this form to your computer before proceeding.

|  |  |
| --- | --- |
| 1. General Information | |
| **Principal Investigator:** | **Version Date:** |
| **Faculty Advisor:** | **Protocol Number:** |
| **Study Title:** | |

| 1. Study Information | | | | | |
| --- | --- | --- | --- | --- | --- |
| * 1. Will a physician or consulting physician be involved in the project? | | | | | |
|  | Yes  No | | If "Yes", complete the following: | | |
|  | | Physician Name:  Licensure:  License Number:  State: | |  | |
|  | | | | | |
| * 1. How long with this study last? | | | | | |
|  |  | | | |  |
|  | | | | | |
| * 1. Will healthy subjects be studied? | | | | | |
|  | Yes  No | | If "Yes", complete the following: | | |
|  | | Number:  Age Range:  Sex:  Hospitalization requirements: | |  | |
|  | | | | | |
| * 1. Will subjects with manifest or suspected disease be studied? | | | | | |
|  | Yes  No | | If "Yes", complete the following: | | |
|  | | Number:  Age Range:  Sex:  Hospitalization requirements:  Description of the pathology: | |  | |
|  | | | | | |
| * 1. Will females be studied? | | | | | |
|  | Yes  No | | If "Yes", will screening for pregnancy be appropriate?  Yes  No  Explain: | | |
|  | | | | | |
| * 1. Are there any subject restrictions? | | | | | |
|  | Yes  No | | If "Yes", describe: | | |
|  | | | | | |
| * 1. Will subjects be fully informed of the nature and purpose of the procedure? | | | | | |
|  | Yes  No | | If "No", explain: | | |
|  | | | | | |
| * 1. Describe screening procedures and attach a copy of the screening document(s)? | | | | | |
|  |  | | | | |
|  | | | | | |

| 1. Radiation information | | | | | | | | | | | |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| * 1. Complete the following: | | | | | | | | | | | |
|  | | **X-Rays** | | **Procedure** | **Max #** | **Views** | | **Dose/Procedure\*** |  |
|  | | **Diagnostic X-Ray** | |  |  |  | |  |  |
|  | | **Fluoroscopy** | |  |  |  | |  |  |
|  | | **Computed Tomography** | |  |  |  | |  |  |
|  | | **Bone Densitometry** | |  |  |  | |  |  |
|  | | **Mammography** | |  |  |  | |  |  |
|  | | **Linear Accelerator** | |  |  |  | |  |  |
|  | | | | | | | | | | | |
|  | |  | | **Nuclear Medicine** | | | **Therapy Implants** | |  |
|  | | **Radioactive Materials** | |  | | |  | |  |
|  | | **Procedure** | |  | | |  | |  |
|  | | **Activity and Radionuclide** | |  | | |  | |  |
|  | | **Intravenous Administration** | |  | | |  | |  |
|  | | **Maximum Number** | |  | | |  | |  |
|  | | **1) Organ of interest**  **2) Critical Organ** | |  | | |  | |  |
|  | | **Dose (mrem)to:**  **1) Organ of interest**  **2) Critical Organ** | |  | | |  | |  |
| ***\*For Dose information, call the Radiation Safety Officer at 541-346-2864*** | | | | | | | | | | |
|  | | | | | | | | | | |
| * 1. Which method will be used to minimize patient radiation dose? | | | | | | | | | | |
|  |  | | Gonad shielding | | | | | | | |
|  |  | | Other - Describe: | | | | | | | |
|  | | | | | | | | | | |
| * 1. Indicate which is true of the description and sketches of special devices to be used in patients. | | | | | | | | | | |
|  |  | | Attached | | | | | | | |
|  |  | | On file with the Radiation Safety Office; refer to application date | | | | | | | |
|  |  | | Not applicable | | | | | | | |
|  | | | | | | | | | | |