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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.

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

| 1. Study Information
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| --- |
| * 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 |
|  |