As the Principal Investigator for the following study: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, either myself or my representative has discussed with the following Service Chief(s) their willingness to provide the needed educational and support resources for this study **once the study has been approved by the IRB and Research and Development Committee**. Services not directly involved in the protocol will be notified of the pending research in writing (e.g. e-mail or interdepartmental mail) and will be provided additional information at their request.

DENTAL MEDICAL OPTOMETRY PSYCHIATRY

LABORATORY NURSING PHARMACY SURGICAL

RADIOLOGY OTHER

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature—PI/Date

# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signing below signifies that the Principal Investigator or his/her representative has discussed the above named study with me and that I am willing to provide educational and support resources needed to carry out this study **once the study has been approved by the IRB and Research and Development Committee**. I have reviewed the abstract and, when required, have had a copy of the entire protocol provided to me for review.

**DENTAL SERVICE OPTOMETRY SERVICE**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature—Service Chief/Date Signature—Service Chief/Date

**LABORATORY SERVICE PHARMACY SERVICE**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature—Service Chief/Date Signature—Service Chief/Date

**MEDICAL SERVICE PSYCHIATRY SERVICE**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature—Service Chief/Date Signature—Service Chief/Date

**NURSING SERVICE SURGICAL SERVICE**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Signature—Service Chief/Date Signature—Service Chief/Date

**RADIOLOGY SERVICE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SERVICE**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Signature—Service Chief/Date Signature—Service Chief/Date

The above protocol has been reviewed with me.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature—PI’s Supervisor Date**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Signature—Chief of Staff Date