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