

**LOYOLA UNIVERSITY HEALTH SYSTEM
RESEARCH STUDY NOTIFICATION FORM**

LU #:	Department:	Grant Account # (if known):
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Project Title:

Short Project Title (identify short title for use by patients when registering):

Principal Investigator (Name):

Extension:

Contact Person for the Study:

Title: (research coordinator, PI, Dept. Administrator)

Extension: Fax #:

Mailing Address (building & room #):

Research Related Services *(check all that apply):

Patient Financial Services(PFS) Physician Services (LUPF) Inpatient Outpatient

Are any charges to be waived?

Yes No

If yes, attach supporting approval letter (s)

Will an investigational device, drug or procedure be part of this clinical trial?

Yes No

If yes to above; has prior approval been obtained for 3rd party payment of services related to the study (i.e. Medicare, Medicaid, private insurers)?

Yes No

If yes, attach relevant approvals

* Attach approved, itemized, detailed budget