

**SUTTER INSTITUTE FOR MEDICAL RESEARCH**  
**Application for Research Grant**  
 Cover Page

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

<b>Principal Investigator</b>	Last Name:	First Name:	Title:
	Mailing address:		
	Email address:		
	City:	State:	Zip:
	Phone:	Fax:	Pager:
	Best method of contact: email <input type="checkbox"/> phone <input type="checkbox"/> pager <input type="checkbox"/> other:		
<b>Co-Investigator</b>  <b>or</b>  <b>Sub -Investigator</b>	Last Name:	First Name:	Title:
	Mailing address:		
	Email address:		
	City:	State:	Zip:
	Phone:	Fax:	Pager:
	Best method of contact: email <input type="checkbox"/> phone <input type="checkbox"/> pager <input type="checkbox"/> other:		
<b>Project Title:</b>			
<b>Project Type:</b>	<input type="checkbox"/> Laboratory research	<input type="checkbox"/> Clinical research	<input type="checkbox"/> Clinical outcomes
	<input type="checkbox"/> Quality improvement		
<b>Project Timeline:</b>	<input type="checkbox"/> 1-year		
	<input type="checkbox"/> 2-years		
	Begin date:	End date:	

**Please complete the following:**

Have the appropriate regulatory documents (IRB, HIPAA, ACUC) been filed?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Date to be reviewed by appropriate committee: ____ / ____ / ____
Will investigational drugs be used?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Will the project require the use of hazardous materials?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Will Sutter Hospital or other Sutter space be required?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Is the research likely to lead to a patent application?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Is the project a preliminary study to apply for other funding?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Is the purchase or lease of equipment involved?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	
Are hospital or other funds required for cost sharing or matching?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, indicate amount \$ Source:
Are cooperating institutions involved in the project?	Yes <input type="checkbox"/>	No <input type="checkbox"/>	If yes, list institutions

**SIGNATURES:**

Principal Investigator: \_\_\_\_\_ Date: \_\_\_\_\_

Co-Investigator: \_\_\_\_\_ Date: \_\_\_\_\_

Co-Investigator: \_\_\_\_\_ Date: \_\_\_\_\_

Program Manager: \_\_\_\_\_ Date: \_\_\_\_\_

Assistant Administrator \_\_\_\_\_ Date: \_\_\_\_\_