CREIGHTON UNIVERSITY MEDICAL CENTER
COST SHEET AND APPROVAL OF RESEARCH PROTOCOLS FORM

Attach a copy of the entire protocol, Informed Consent and coverage analysis to this Cost Sheet

Project Name: _____
Principal Investigator: _____
Person responsible for completing this cost sheet and to whom questions should be directed for billing:

_____ _____ _____ _____
Print Name Department Telephone E-mail

Has the Creighton University IRB approved this project? Yes ☐ IRB Number: _____
No ☐ If no, please indicate the anticipated date for submitting the project to the IRB: _____

Proposed Start Date: _____ Estimated Completion Date: _____

This Study will require the following services (multiple boxes may be selected):

☐ Lab Services
☐ Pharmacy Services
☐ Cardiology Services
☐ Pulmonary Services
☐ Radiology or Interventional Radiology Services
☐ Inpatient/Overnight Stay
☐ No Services Requested

Department to be charged for the requested services: _____ Fund/Org Numbers: _____

Are patients to be billed for the requested services?
Yes ☐ If yes, please indicate any restrictions (e.g., do not bill patient's insurance): _____
No ☐ If no and patient will be registered at CUMC then completion of this form is required

Will patients receive a series of the services? Yes ☐ No ☐
Yes, the Hospital's electronic medical records for these services will be stored in one folder. This will enable you to access the series with one file number and will require only one signed informed consent form to be submitted.

Does this project involve use of an implantable device? Yes ☐ No ☐
If yes, (a) what is the name of the device: _____
(b) is the device FDA approved for this use? Yes ☐ No ☐
(c) the Chair of any involved Hospital Department having control of such devices must approve:

_____ _____ _____
Name Department/Section/Service Date

Does this project involve an invasive procedure (e.g. surgical, endoscopy, etc)? Yes ☐ No ☐
What procedure(s)? _____
What physician will be performing the procedure(s)? _____
Does the physician have Hospital medical staff privileges for the procedure? Yes ☐ No ☐
Medical Staff Services verification:

_____ _____
Name Date

Does this project involve any drugs for inpatients or observation patients? Yes ☐ No ☐
If yes, the Inpatient Director of Pharmacy Services and the Chair of the Hospital P & T Committee must approve:

_____ _____ _____ _____
Director of Pharmacy Services Date Chair of P & T Committee Date

CREIGHTON UNIVERSITY MEDICAL CENTER RESEARCH COST SHEET FOR PHYSICIAN SERVICES (INCLUDING DIAGNOSTIC PROFESSIONAL COMPONENT), LAB, HOSPITAL INPATIENT AND/OR OUTPATIENT SERVICES

Principal Investigator: _____ IRB #: _____

Study Coordinator: _____ Phone Number: _____ E-mail: _____

Study Name: _____

Number of Subjects to be enrolled: _____

Anticipated date to be submitted for IRB Review: _____

Services Requested (list professional components separately)	HCPCS/CPT or APC Code	Estimated times per subject	Bill Study (√)	Unit Price Quote
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$
				$

This Price Quote is based upon the research protocol submitted with this request and is valid until the end of the study if the study is commenced prior to December 31 of the year in which the cost sheet is completed. If the study is not commenced prior to December 31 of the year in which the cost sheet is completed, new price quotes must be obtained.

_____ _____
Principal Investigator Date

_____ _____
CUMC Hospital Compliance Office (Tiffany Thompson) Date

_____ _____
CUMC Hospital Vice President for Medical Affairs (Robert Dunlay, M.D.) Date

_____ _____
CUMC Hospital Chief Financial Officer (Kerry Tolleson) Date

IRB Final Approval Letter Date/Initials_____