**RESEARCH APPLICATION PACKAGE B**

**Epidemiological Studies or Retrospective Data Analysis**

**Instructions for Completion and Submission:**

Application package B is to be used for **new** epidemiological or retrospective data analysis studies. Please refer to packages A and C for quantitative/qualitative studies involving human participants, and emergency approvals, respectively. Submit the completed application, along with all required supporting documents (listed below) to the Trillium Health Partners REB. Complete applications received by the 1st weekday of the month will be reviewed at the Research Ethics Board meeting held on the 3rd Thursday of that month. The submission of incomplete packages may result in delays in REB review.

Please contact the REB Coordinator at [THPREB@thp.ca](mailto:THPREB@thp.ca) with questions regarding the Application Submission Form or the submission process.

**Notification of Privacy Breaches:**

If during the course of the study, the Sponsor(s), Principal Investigator, Co-investigator(s) or study co-ordinator(s) become aware that the privacy of study subjects has been breached, please contact the Chair of the Research Ethics Board. The Chair will address the incident in keeping with Trillium Health Partners’ *Incident Reporting and Management* protocol.

**Application Submission Checklist:**

One copy of each of the following Forms/Attachments is required:

Completed typed application form – Attach:

* Appendix A – Resource Impact Estimate Form
* Appendix B if there is **no** contract – Sponsor Certification
* Appendix C if there **is** a contract – Investigator Certification

The full study protocol

All questionnaire(s)/study instruments(s) to be used in this study

Itemized Study Budget

Sample Consent Form(s)/Assent Form(s) – if applicable

Advertisements or other recruitment tools - if applicable

Any other documents that will be given to subjects

Your completed application package should be submitted via email to the Trillium Health Partners Research Ethics Board [THPREB@thp.ca](mailto:THPREB@thp.ca)

**APPLICATION B - Epidemiological Study/Retrospective Data Analysis**

## Section I: GENERAL INFORMATION

**1. Full Study Title**:

**2. Applicant:**

a. Principal Investigator

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Title: | | First Name: | | Surname: | |
| Street Address  Line 1 | | | | | |
| Line 2 | | | | | |
| City | Province/State | | Postal/Zip Code | | Country |
| Telephone | Pager | | Email | | Fax Number |

PI Agreement – I certify that the methods I will use to conduct this study are in compliance with the Tri-Council Policy Statement, ICH Good Clinical Practices: Consolidated Guidelines, Division 5, Canadian Food and Drug Regulations (if applicable), the Personal Health Information Protection Act, and all other applicable laws and regulations. This application contains the current and complete protocol, including any sub-studies.

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Signature of Principle Investigator (PI) Date

b. Co-Investigators (please list):

c. Clinical Trials Nurse/Study Coordinator (if applicable):

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Title: | | First Name: | | Surname: | |
| Institution | | | Department/Division | | |
| Street Address  Line 1 | | | | | |
| Line 2 | | | | | |
| City | Province/State | | Postal/Zip Code | | Country |
| Telephone | Pager | | Email | | Fax Number |

d. Trillium Health Partners Contact:

**3. Sponsor:**

a. Sponsor Protocol # and Version Date:

**4. Scientific Peer Review/External Ethics completed?**

Yes  No  Pending  Date       Not Planned

Contact Name and Phone Number:

**5. Study Period:**

Expected Start Date:

Anticipated Total Study Duration:

## Section II: STUDY SUMMARY

NOTE: THIS IS NOT A SUBSTITUTE FOR THE FULL PROPOSAL.

**6. Abstract:** Must be a summary of study **suitable for lay audience**; maximum 100 words. Please note that this abstract may be used to generate reports, which may be disseminated to various stakeholders.

**7. Rationale and Hypothesis/Research Question:**

**8. Protection of Personal Health Information (Principle Investigator)**

**a. Accountability**

i. Please describe how you ensure that all of your staff and agents are appropriately informed of their duties regarding protection of the study subject’s personal health information.

ii. Please describe how you protect personal health information that is disclosed to a third party (other than the sponsor).

Not applicable

     

**b. Access to and Disclosure of the study subject’s personal health information**

i. Please list the name, affiliation, roles and qualifications of everyone working on the research and accessing the study subject’s personal health information.

     

ii. Please state justification for disclosing the participant’s study record to these persons.

     

iii. Please indicate if you will be disclosing the study subject’s personal health information to anyone other than those listed above, and why.

Not applicable

**c. Consent to collection, use and disclosure of the study subject’s personal health information**

The informed consent form is the mechanism by which the sponsor obtains permission to collect, use or disclose a study subject’s personal health information.

i. Will express consent from study subjects be sought to access their personal health information?

*YES  NO*

**If yes, the consent form on institutional letterhead must be included with the application. Please refer to the *Guidelines for Research Project Consent Documents* for more detailed instructions**.

If no, provide rationale:

ii. You collect a study subject’s personal health information on behalf of the sponsor. If you are going to use or disclose the information for reasons other than the study (secondary uses), you must provide the study subject with the ability to accept or refuse the secondary uses and still participate in the study. Please describe how permission was/will be obtained.

Not applicable

iii. Explain how you will address withdrawal of the study subject’s consent to secondary uses.

Not applicable

**d. Retention, accuracy, safeguards to protect confidentiality and security, and disposal of the study subject’s personal health information**

i. Will you be storing the study subject’s personal health information?

YES  NO

ii. How long will you be storing the study subject’s personal health information?:

You must contact the hospital if a study subject’s personal health information is lost, stolen or accessed in an unauthorized manner. You must not contact the study subject directly.

iii. Indicate how the study subject’s personal health information will be stored:

Electronic (computerized files)

Physical (hard copy, audio recordings, video tape, other – please specify)

iv. Regarding electronic storage, please describe how you safeguard the confidentiality and security of the information (e.g. type of identifiers, methods to anonymize the data, access controls, whether the database resides on a computer that also has internet service, and in such an instance whether you have installed software to prevent hacking and cookies such as spyware):

v. Regarding physical storage, please describe how you safeguard the confidentiality and security of the information.

**e. Will a study subject’s personal health information be transferred electronically?**

YES  NO

If yes, by what medium, and how do you safeguard the confidentiality and security of the information that is being transferred (e.g. CD’s or floppy discs protected by passwords, encryption)?

**f. How will you dispose of the study subject’s personal health information at the end of the study?**

**g. In the event of unanticipated harms or benefits identified through the sponsor’s ‘use’ of the study subject’s personal health information for future studies, will you be involved in ‘track-back’?**

YES  NO

If yes, in the context of storage and disposal, how will you address ‘track-back’?

**9. Continuing Review**

Indicate the suggested level of continuing review required for this study (check all that apply):

Annual renewal

More frequent renewal; indicate interval in months

Other (eg. Audit, observation of consent process, interview with participants)

Please specify:

**10. Conflict of Interest**

Are you aware of any actual or apparent Conflict of Interest\* for any Investigators or Co-investigators involved in this research study or any member of their immediate family?

YES  NO

If YES, please append a letter detailing these activities to Trillium Health Partners REB. Please disclose any conflicts of interest (actual, apparent, perceived, or potential) relating to this project.

\*Examples of activities that may be a conflict of interest include:

* Functioning as an advisor, employee, officer, director, or consultant for the study sponsor?
* Having direct or indirect financial interest in the drug, device, or technology employed (including patents or stocks) in this research study?
* Receiving an honorarium or other personal benefits from the sponsor (apart from fees for service)?
* Receiving a recruitment initiative or bonus (eg. For meeting enrolment targets)?

**11. Publication/Dissemination of Results**

How will the results be communicated to participants and other stakeholders (eg. advocacy groups, scientific community)?

Check all that apply:

Individual debriefing at end  Publication (eg. journal article,

of test session presentation)

Group debriefing  No plan

Letter of Appreciation at end of study

Other (please specify):

**Section IV: RESOURCE IMPACT AND CONTRACTS**

# FUNDING

**No Funding Required (explain)**

**Funding Required**

Source:

Obtained Applied for (expected date of decision):

*Do the funds presently available or applied for cover all requirements to conduct the project?*

*YES  NO*

If NO, please explain how the shortfall will be made up:

**IMPACT ON TRILLIUM HEALTH PARTNERS:**

*Trillium Health Partners is not a funded academic research centre. We must ensure that participation in research projects does not decrease funding available for our primary focus of provision of patient care. The investigator is expected to work with the hospital to develop a plan to address additional costs that can be attributed to the study. Costs are reviewed annually and the funding plan may be adjusted annually.*

**Please Note: It is the Investigators responsibility to ensure that there is a mechanism in place to capture and cover these costs on a continuous basis.**

Identify the services that will be impacted by this research project. Provide the name of the nursing unit if the patient will be admitted. A completed & signed Study Cost Estimate Form for each impacted area must be attached at the time of application.

Administrative, e.g. contract review  Health Records  Other, please specify:

**11. HEALTH RECORDS UTILIZATION**

a. Will you require access to patient files through the Health Records Department?

Yes  No

b. Will you require access to nursing notes or medication administration records through the Health Records Department?

Yes  No

c. If you require access to the same files more than once please include an estimate the

total number of files.      

d. Will you need help to identify your research population?

Yes  No

e. Will you require statistics from Health Records for your project?

Yes  No

**12. OTHER**

Please describe the workload implications for any other services identified in the top section of this question:

**ENSURE THAT A GENERIC COST STUDY ESTIMATE FORM (Appendix A) IS ATTACHED FOR EACH IMPACTED DEPARTMENT**

**13. HEALTH SYSTEM (S) REVIEW**

The following individuals who have been identified as the key Trillium Health Partners system(s) clinical and administrative contacts for this study, have reviewed the above study and have determined that there are sufficient methods in place to protect the personal health information associated with the study subject and have determined that there is sufficient scientific and ethical merit to the study to recommend approval:

Name:       Signature: ­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:      

Name:       Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:

**14.** **CONTRACT**

**Is there a contract involved for this study?**

YES  NO

**If YES, attach the contract.**

* **Attach Appendix C**
* **Name of sponsor(s)/agencies on contract:**

If **NO** contract involved:

* Do not complete the remainder of this section
* Attach Appendix B and C

**If YES:**

* + 1. **Name of sponsor(s)/agencies on contract:**

* + 1. **Liability Insurance:**

Is there liability insurance?

YES  NO

* + 1. If the subject suffers an injury as a result of participation in the study, who will cover reasonable out-of pocket expenses to ensure that immediate medical care is provided?

Sponsor  Institution

Other (Please specify):      

**C. Publication Agreements:**

i. Is there an agreement between the investigator and the sponsor regarding use, publication or disposal of the data?

YES  NO

If YES, does the funding agency or sponsoring company place any restrictions on publication of findings or reporting of interim results?

### YES NO

If YES, explain any restrictions:

ii. Does the contract permit the disclosure of research results, including SAEs, to stakeholders (subject and/or guardian, sponsor, REB, REBs of other sites, and regulatory agencies) if required to protect the health of subjects?

YES  NO

**D. Does the funding agency or sponsoring company place any restrictions on publication of findings or reporting of interim results?**

YES  NO

If YES, indicate and explain any restrictions:

**Appendix A: RESOURCE IMPACT ESTIMATE FORM**

**This form is to be completed by the Principal Investigator with input from each Health System or department where costs may be incurred specifically due to the research project. Only additional costs should be calculated i.e., costs that are not part of the regular component of care provided by your department for patients of a similar diagnosis.**

Calculate on a per patient basis.

**1. Health System/Department name:**

**2. Short title of research project/Principal Investigator Contact information:**

**3. Definition of the typical use of service your department provides for patients with the same diagnosis outside the research project.**

**4. Description of additional costs[[1]](#footnote-1)[[2]](#footnote-2):**

|  |  |
| --- | --- |
| **Description** | **#/patient (over/above standard of care)** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**Provide billing address:**

**6. Additional comments or concerns about the study.**

**7. Director/Manager Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:**

1. **Health Systems Chief/Department Head Signature:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:**

* 1. **Principal Investigator or Designate Signature (this signature acknowledges the impact as outlined above and a commitment for provision of reimbursement to the specified HS/Dept):**

**Signature: ­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:**

**Appendix B: SPONSOR CERTIFICATION (to be signed if there is *no* Contract)**

I certify that:

1. No study records that contain personal health information will be disclosed to any organizations/countries that do not subscribe to ICH GCP.
2. The methods I/we will use to conduct this study are in compliance with the Tri-Council Policy Statement, ICH Good Clinical Practices: Consolidated Guidelines, Division 5, Canadian Food and Drug Regulations (if applicable), the Personal Health Information Protection Act, and all other applicable laws and regulations.

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Signature of Sponsor Date

**Appendix C: INVESTIGATOR CERTIFICATION**

I acknowledge that I am a Health Information Custodian as defined in the Personal Health Information Protection Act.

I certify that:

1. No study records that contain personal health information will be disclosed to any organizations/countries that do not subscribe to ICH GCP.
2. The methods I/we will use to conduct this study are in compliance with the Tri-Council Policy Statement, ICH Good Clinical Practices: Consolidated Guidelines, Division 5, Canadian Food and Drug Regulations (if applicable), the Personal Health Information Protection Act, and all other applicable laws and regulations.

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Signature of Principle Investigator (PI) Date

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Signature of Co-Investigator(s) Date

1. For all Diagnostic Imaging services testing, the cost per service/test is as per OHIP guidelines. [↑](#footnote-ref-1)
2. For all Health Records service usage, and all Laboratory Services testing, the costs per service used are as per Trillium Health Partners’ established rates. [↑](#footnote-ref-2)