**SCREENING DETERMINATION FORM: QUALITY IMPROVEMENT OR RESEARCH?**

**Part 1: Contact Information**

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| Name of Project Lead\*:      | Request Date:      (DD/MMM/YYYY) |
| Department:       | Email Address:       | Phone Number:      |
| Name of Person Completing the Form:      |
| Department:       | Email Address:       | Phone Number:      |

**Part 2: Project Information**

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| Project Title:      |
| Summary of the Project (this should include a brief description of the planned activity, the participant population and methods involved, the purpose of conducting the project and evaluation framework):      \*\*\*If a more detailed plan exists, this may also be appended to provide additional information (may be in the form of a project charter, proposal or protocol)\*\*\* |

**Part 3: Questions**

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| **Question** | **Response** | **Describe/Comment** |
| 1. Is there a non-Sinai Health System party/ institution/ organization involved? | [ ]  Yes | [ ]  No | If yes, please list the organization(s):       |
| 2. Is there funding for this project? | [ ]  Yes | [ ]  No | If yes, please list the funding source(s):       |
| 3. Will human biological samples be collected, used or disclosed? | [ ]  Yes | [ ]  No | If yes, please explain the purpose and who will have access to these samples:       |
| 4. Will personal health information be collected, used or disclosed? | [ ]  Yes  | [ ]  No | If yes, please describe:       |
| 5. Will any other identifying information be collected, used or disclosed? | [ ]  Yes  | [ ]  No | If yes, please describe:       |
| 6. Do you plan to disseminate your findings outside of Sinai Health System (e.g., present at a conference, publish a paper)?  | [ ]  Yes  | [ ]  No | If yes, please describe:       |
| 7. Is the intent of the project to produce results that would be generalizable beyond the population under study? | [ ]  Yes  | [ ]  No | If yes, please describe:       |
| 8. Does this project involve any potential risks or harms (injury, discomfort or inconvenience, including psychological factors) or additional/substantial burdens to participants? | [ ]  Yes  | [ ]  No | If yes, please describe:       |

**Part 4: Signatures**

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| **Project Lead Agreement:**I assume full responsibility for the project described in this form and certify that all personnel involved in this proposal at this institution are appropriately qualified or will undergo appropriate training to fulfill their role in this project. |
| Signature of Project Lead:      | Date:      (DD/MMM/YYYY) |
| **Department/Division/Program Head Approval:**I am aware of this proposal and support its submission for screening determination. I attest that the Project Lead responsible for the conduct of this project is qualified by education, training, and experience to perform this role. |
| Title:       | Last Name:       | First Name:      |
| Signature of Dept/Div/Program Head:      | Date:      (DD/MMM/YYYY) |

\*Please note that the Project Lead must be a staff member with Sinai Health.