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| Office Use Only: REB No. |  |

**Instructions for Completion and Submission:**

This application is to be used for ***external*** research studies involving human participants wishing to receive authorization to recruit participants through Lakeridge Health staff and/or patient population. All advertisement and recruitment documents must receive Institutional approval prior to posting or distribution at Lakeridge Health. The completed application, along with all the required supporting documents (listed below) must be submitted to the REB Coordinator at Lakeridge Health. The submission of incomplete packages may result in delays of review and approval.

THIS DOCUMENT MUST BE COMPLETED ELECTRONICALLY.

Please contact Lori-Ann Larmand, Research Liaison/REB Coordinator at REB@lh.ca with questions regarding the application submission form or the submission process.

**Application Submission Checklist:**

Please check off all that apply and provide a copy of each:

|  |  |
| --- | --- |
| [ ]  | Study Protocol (mandatory) |
| [ ]  | REB Approval Letter from Researcher’s Site (mandatory) |
| [ ]  | Study Flyer |
| [ ]  | Study Poster |
| [ ]  | Study Brochure |
| [ ]  | Study Information Letter |
| [ ]  | Other Advertisements or Recruitment Tools (if applicable):  |

*Lakeridge Health Requirements:*

* *All advertisements/recruitment tools must contain the name of the approving Research Ethics Board*
* *Posters must be on material that is wipeable*
* *Poster Size Options: 1). 11x17 – recommended; 2) 18x24; 3). 8.5x11 – if small posting area, inquire with LH Contact*

Your completed application package should be submitted via email to Lori-Ann Larmand, Research Liaison/REB Coordinator at REB@lh.ca.

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| **Person Completing Application:** |  | **Submission Date:**(dd-mmm-yyyy) |  |

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| **SECTION 1: GENERAL INFORMATION** |
| 1. | **Full Study Title**: |
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| 2. | **Start Date at LH:**(dd-mmm-yyyy) |  | **End Date at LH:**(dd-mmm-yyyy) |  |
| 3. | **List all programs, service and/or departments that will be targeted:**  |
|  |
| 4. | **Fill in all contact information in the section below.** |
| **Study Role** | **Name/** **Credentials** | **Institution /** **Department / Address** | **Tel No.** | **Email** |
| External Researcher |  |  |  |  |
| LH Staff Contact |  |  |  |  |
| 5. | **Will any study activity occur at Lakeridge Health beyond recruitment?** [ ]  Yes [ ]  No  |
| If yes, specify: |  |

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| **SECTION 2: RECRUITMENT PROCESS** |
| 6. | **How will potential participants be identified and/or referred?**[ ]  Healthcare Professional [ ]  Advertisements/web-based recruitment tools [ ]  Other |
| If other (specify):  |  |
| 7. | **Explain who will make initial contact with participant and how (*e.g., in person, phone, letter, email/web site*) and if applicable, attach a copy of the script and/or any written material**. |
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| 8. | **How will the recruitment material be supplied?** |
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| 9. | **How will the recruitment material be distributed?** |
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| 10. | **How and where will the recruitment material be displayed?** |
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| 11. | **How will the recruitment material be maintained?** |
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| 12. | **How will the recruitment material be removed at the end of the study period?** |
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| 13. | **Have any provisions been made for participants who do not speak English?** [ ]  Yes [ ]  No |
| Describe: |  |

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| **SECTION 3: APPROVAL AND DECLARATION**  |
| **PROGRAM DIRECTOR APPROVAL FOR THIS SUBMISSION****Program Director Approval** - I am aware of proposed recruitment material/ study information and support its display and dissemination in this program. I understand that further research activity will not be permitted without the full approval of the Institution. |
|  |  |  |  |  |  |  |
|  | Program Director Name |  | Program Director Signature |  | Date*(dd-mmm-yyyy)*: |  |
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| **LAKERIDGE HEALTH STAFF CONTACT**I am aware of the proposed recruitment material/ study information and accept responsibility for its display and dissemination at Lakeridge Health. I agree to act as a “contact person” should additional information be requested and understand that further research activity will not be permitted without the full approval of the Institution. I agree to notify the REB Coordinator if it is determined that study activity differs from what is approved herein. |
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|  | Lakeridge Health Contact Name |  | Lakeridge Health Contact Signature |  | Date*(dd-mmm-yyyy)*: |  |