**Baltimore City Health Department**

**Public Health Review**

**New Project Application**

Once you have obtained IRB approval, please fill out this form and submit, along with the research protocol and proof of IRB approval, to paul.overly@baltimorecity.gov. We will complete the review within four weeks. If you received approval from a Johns Hopkins Medical Institution IRB, all you need to do is submit this form; your protocol and proof of approval are submitted to us automatically.

**Name of PI:**

**Address 1:**

**Address 2:**

**Address 3:**

**City:** **State:** **Zip Code:**

**Name of contact person (if not PI):**

**E-mail address:**

**Title of research project:**

**Name of IRB from which you obtained approval:**

**IRB approval date (enter as mm/dd/yyyy):**

**IRB protocol number:**

**Health Department Collaborator:**

1. **Briefly describe the goals and methods of the research study.**

1. **BCHD and Client Involvement**

Please complete applicable sections

**Participant Recruitment**

Number of participants to be recruited through BCHD:

**Passive recruiting only?** (i.e., posters, pamphlets) [ ]  Yes [ ]  No

# Content of recruitment materials subject to reviewer approval. Submit materials with application.

**Active recruiting**

By BCHD staff? [ ] Yes [ ]  No Time required per prospect:       minutes

Plan for compensation for BCHD staff time:

By research staff? [ ]  Yes [ ]  No Office/desk required? [ ]  Yes [ ]  No

Location(s) of recruiting site:

Specify (if Other, Combination, or SBHC):

Anticipated duration of recruitment:

**Clinic Use** (other than for recruitment)

[ ] Yes [ ]  No

If yes, please check area(s) you seek to use:

[ ]  Patient waiting area (complete forms, surveys, etc.)

[ ]  Office space providing privacy/confidentiality

[ ]  Clinical space for treatment, examinations, tests

[ ]  Other (specify)

**BCHD site(s) for other research activities:**

**Specify (if Other, Combination, or SBHC):**

**Anticipated duration:**

**Staff Time**

[ ] Participant/patient appointment management

 Number of participants:

 Expected number of appointments/participant:

[ ]  Other staff time

 Total staff time required per day:       Hours

 Anticipated duration:

Plan for compensation for BCHD staff time:

**Other Clinic Resources**

(Telephones, computers, expendable supplies, etc.)

[ ] Yes [ ]  No

Describe:

Anticipated duration:

Plan for compensation for resource use:

**Data Use**

[ ]  Yes [ ]  No

Describe data required:

Is this readily available? [ ]  Yes [ ]  No [ ]  Do not know

If BCHD must data compile, process, analyze, or otherwise prepare data for your use: Plan for compensation for BCHD staff time:

 **Other BCHD Involvement**

 If your research requires BCHD involvement not covered by any of the above, please specify:

Plan for compensation for BCHD resources/staff time:

1. **Describe the benefits to Baltimore residents that will accrue through the study.**