**Ionizing Radiation**

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| --- |
| **Purpose:**  This form is designed to provide information to the IRB for human subjects research involving the use of ionizing radiation. |

**Instructions:** Complete only if your research activities will include the use of ionizing radiation.

* Respond to every question on this application. Incomplete applications will be returned, and will result in a delay of your study being reviewed. If a question does not apply, answer N/A. Do not leave any question blank.
* This form must be uploaded when submitting a Research Plan for a New Study or Modification activity through the IRB Module of the Research Administration Portal (RAP).
* Save this form to your computer before proceeding.

**General information for investigator’s reference (optional):**

|  |  |  |  |
| --- | --- | --- | --- |
| Principal  Investigator (PI): |  | Faculty Advisor: |  |
| Study Title: |  | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. Study Information | | | | |
| * 1. Will a physician or consulting physician be involved in the project? | | | | |
|  | Yes  No | | If "Yes", complete the following: | |
|  | | Physician Name: |  |  |
|  | | Licensure: |  |
|  | | License Number: |  |
|  | | State: |  |
| * 1. How long with this study last? | | | | |
|  |  | | | |
| * 1. Will healthy subjects be studied? | | | | |
|  | Yes  No | | If "Yes", complete the following: | |
|  | | Number: |  |  |
|  | | Age Range: |  |
|  | | Sex: |  |
|  | | Hospitalization Requirements: |  |
| * 1. Will subjects with manifest or suspected disease be studied? | | | | |
|  | Yes  No | | If "Yes", complete the following: | |
|  | | Number: |  |  |
|  | | Age Range: |  |
|  | | Sex: |  |
|  | | Hospitalization requirements: |  |
|  | | Description of the pathology |  |
| * 1. Will females be studied? | | | | |
|  | Yes  No | | If "Yes", will screening for pregnancy be appropriate? | |
|  |  | | ☐ Yes ☐ No | |
| Explain below: | | | | |
|  |  | | | |
| * 1. Are there any subject restrictions? | | | | |
|  | Yes  No | | If "Yes", describe below: | |
| * 1. Will subjects be fully informed of the nature and purpose of the procedure? | | | | |
|  | Yes  No | | If "No", explain below: | |
|  |  | | | |
| * 1. Describe screening procedures and attach a copy of the screening document(s)? | | | | |
|  |  | | | |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| 1. Radiation information | | | | | | | | |
| * 1. Complete the following: | | | | | | | | |
|  | | | | | | | | |
|  | | X-Rays | | Procedure | Max #  Views | | Dose/Procedure\* |  |
|  | | Diagnostic X-Ray | |  |  | |  |  |
|  | | Fluoroscopy | |  |  | |  |  |
|  | | Computed Tomography | |  |  | |  |  |
|  | | Bone Densitometry | |  |  | |  |  |
|  | | Mammography | |  |  | |  |  |
|  | | Linear Accelerator | |  |  | |  |  |
| ***\*For Dose information, call the Radiation Safety Officer at 541-346-2864*** | | | | | | | | |
|  | |  | | Nuclear Medicine | | Therapy Implants | |  |
|  | | Radioactive Materials | |  | |  | |  |
|  | | Procedure | |  | |  | |  |
|  | | Activity and Radionuclide | |  | |  | |  |
|  | | Intravenous Administration | |  | |  | |  |
|  | | Maximum Number | |  | |  | |  |
|  | | 1) Organ of interest  2) Critical Organ | |  | |  | |  |
|  | | Dose (mrem)to:  1) Organ of interest  2) Critical Organ | |  | |  | |  |
|  | | | | | | | | |
| * 1. Which method will be used to minimize patient radiation dose? | | | | | | | | |
|  |  | | Gonad shielding | | | | | |
|  |  | | Other – describe below: | | | | | |
|  |  | | | | | | | |
| * 1. Indicate which is true of the description and sketches of special devices to be used in patients. | | | | | | | | |
|  |  | | Attached | | | | | |
|  |  | | On file with the Radiation Safety Office, refer to application date | | | | | |
|  |  | | Not applicable | | | | | |