**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 when the radiation is taking place because of the research or is impacted by the research. |

**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: |        |

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| 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 will 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)?
 |
|  |       |

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| 1. Radiation information
 |
| * 1. Complete the following:
 |
|  |
|  | Radiation | 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 541-346-3197*** |
|  |  | 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 |