Mount Sinai	**Mount Sinai Hospital**	
	Apheresis Center, Blood Bank and Cellular Therapy Laboratory	
	Department of Pathology, Molecular and Cell-Based Medicine	
	RESEARCH PARTICIPATION REQUEST FORM	
	General Contact:	**212-241-8810**
	Apheresis Center:	Dr. Suzanne Arinsburg, Medical Director Phone: 212-241-3690 suzanne.arinsburg@mountsinai.org
	Blood Bank:	Dr. Jeffrey Jhang, Medical Director Phone: 212-659-8181 jeffrey.jhang@mountsinai.org
	Cellular Therapy Laboratory:	Dr. Camelia Iancu-Rubin, Laboratory Director Phone: 212-241-8589 camelia.iancu-rubin@mountsinai.org
Please complete, save and send a copy of this form and requested documents to email addresses listed above.		

Principal Investigator	Title	Address	Phone Number	E-mail	Department
Co-Investigators					
Clinical Coordinator (s)					

Study/ Protocol Title/ GCO#/IRB#/IND#
Study/Protocol Design (as pertains to AC, BB or CTL)
ABSTRACT/INTRODUCTION TO THE RESEARCH AND DESCRIBE HOW IT PERTAINS TO APHERESIS, BLOOD BANKING OR CELLULAR THERAPY SERVICES: **SCIENTIFIC FRAMEWORK OF THE RESEARCH PROJECT** (provide 1-2 pages including scientific background, rationale, specific aims and study design):
Estimated Study Dates:
Estimated Study Subjects:

Has the study been submitted to the Investigational Review Board?	**YES:**	**NO:**
Has the study been approved by the Investigational Review Board? If yes, please provide approval letter.	**YES:**	**NO:**
Attach the following as appropriate: • Study protocol • Investigator Brochure • Instructions Manual		

FUNDING:		
Agency:	Please Specify:	Status (Funded/Pending/Applying):
Federal Funding Agency (NIH, DOD)		
Industry Funding		
Research Foundation Funding		
Other Funding		

PAYMENT METHOD (please check one):	
Direct Charge	
Interdepartmental Invoice	
Check	
Account (please provide account number)	
Subcontract	
Other (please specify)	
Please provide invoicing/billing contact (name, phone number, email):	

After receipt and review of the Request Form, our directors will contact the principal investigator/ study contact to determine the extent of Apheresis, Blood Bank or Cellular Therapy Services necessary to support this study. Multiple correspondence and an in-person meeting may be necessary to fully determine the best course of action. Please note time spent preparing study correspondence will be subject to reimbursement and charged at the appropriate time. We look forward to working with you and augmenting your research endeavors.

Principal Investigator/ Study Contact Name:

Signature_____ Date: _____

<u>Apheresis, Blood Bank and Cellular Therapy Use Only:</u>

Reviewed By:_____ Date: _____

Quote Prepared by:_____ Date: _____