|  |
| --- |
| **For obtaining approval for the use of radiation in research.** |
| **All forms must be typewritten, signed, and submitted via email to irb@illinois.edu.** |

|  |
| --- |
| State radiation safety regulations require that all radiation administered to humans must be “authorized by a licensed practitioner of the healing arts.” This includes research as well as medical care. There must be a written approval from a physician (or PA/NP supervised by a physician). The order can be made on a categorical basis, rather than for named individuals.  It is important to note that the physician approval is valid only on an individual protocol basis. A physician cannot approve a researcher or research team for full access to using radiation in their research.  Rather, each individual protocol must be reviewed and approved even if the research use mirrors a previous protocol deemed safe.  For more information, see: <https://www2.illinois.gov/iema/laws/Pages/regs-title32.aspx> |

**Section 1. PROTOCOL INFORMATION**

|  |
| --- |
| **1A. Principal Investigator:** |
| **1B. Protocol Number:** |
| **1C. Project Title:** |

**Section 2. TYPE(S) OF RADIATION**

|  |
| --- |
| **2A. Select all that apply:** |
| DXA/DEXA  X-RAY  PET Scan  CT Scan  Other, please specify: |

**Section 3. ADDITIONAL INFORMATION**

|  |
| --- |
| **3A. Number of subjects that will be administered radiation:** |
| **3B. Age range of subjects that will be administered radiation:** |
| **3C. Explain how will subjects be screened for inclusion into the study:** |
| **3D. Will pregnant women be enrolled in this study?**  Yes  No |
| **3E. Will subjects be consented?**  Yes  No |

**Section 4. SUMMARY**

|  |
| --- |
| **4A. Provide a detailed description of the research procedures involving the administering of radiation to human subjects, including the total amount of radiation and any risks associated with the use of radiation.** |

**Section 5. INVESTIGATOR ASSURANCES**

|  |
| --- |
| I certify that the proposed research will be conducted in accordance to the information provided in the IRB application. I acknowledge that any changes to the approved protocol involving the use of radiation may need to be re-evaluated by a physician. |
| \_\_\_\_\_\_\_\_\_\_  Principal Investigator Date |

**Section 6. PHYSICIAN APPROVAL**

|  |
| --- |
| I certify that the selection criteria and the frequency of testing in this protocol are medically appropriate. |
| \_\_\_\_\_\_\_\_\_\_  Reviewing Physician Signature |
| Physician Contact Information: |