**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: |        |

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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 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)?
 |
|  |       |

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| 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 |