



REQUEST FOR APPROVAL OF CLINICAL PROJECT

Please Complete All Information For Hospital Records. To be considered, the Request must be accompanied by an abbreviated draft of the Project Proposal. Literature Review need not be included. The Project may not be started until all necessary clearances have been obtained, and the form is signed by the Coordinator of Nursing Research who can be reached at (315) 464-4405

Name: _____ Date: _____

Social Security Number: _____ Day Phone: _____ Work Phone: _____

School of Nursing: _____

Advisor for Project: _____

Project Title: _____

Name/Number of Course this Project is to be completed for: _____

Unit or Service you are Requesting Contact With: _____

Unit Contact Person: _____

Signature of Unit Contact Person : _____

First Possible Date on Hospital Unit: _____

Last Possible Date on Hospital Unit: _____

Total Expected Time at University Hospital: _____

Date of Employee & Student Health Clearance: _____

Date of Completion of Hospital Photo ID: _____

I understand that a complete copy of the final project must be filed with the Coordinator of Nursing Research at University Hospital. The date I expect to submit this copy is: _____

Signature of Student : _____ Date: _____

Signature of Coordinator: _____ Date: _____