SUNY UPSTATE MEDICAL UNIVERSITY -- IHP MRI CORE FACILITY
SCANNER USER REQUEST FORM

1. Protocol Title: __________________________________________________________________

2. Principle Investigator: ____________________________________________________________
   Address: _______________________________________________________________________
   Phone: _______________ E-mail: _______________________________ Fax: ______________

3. Collaborators: __________________________________________________________________

4. Subjects: __ Human __ Animal __ Other______________________________________________

5. IRB or CHUA Approval #__________________
   (Please attach copy of cover letter approval)

6. Describe MRI Scanning Requirements: ____________________________________________
   __ Anatomy __ Functional MRI __ 1H Spectroscopy __ Other

7. Number of Requested scanning hours and number of sessions: ______________________
   Estimated duration of project START date to COMPLETION: _______________________

8. MRI Core support for data post processing and/or diagnostic review required? : ____ Y  ____ N
   explain: _______________________________________________________________________

9. Any other special equipment, protocols, or materials: ________________________________
   _____________________________________________________________________________

10. Machine time rate:
    _____ $150/hr UMU Upstate Faculty Dept.,
        Non-funded & exploratory
        # Hours requested: ___________________
    _____ $530/hr UMU Upstate Faculty Dept. funded projects; UMU Hendrick’s funded projects;
        SUNY Upstate External NIH Funded projects
        # Hours requested: __________
    Source of Funding: _____________________________________________________________

    _____ $798/hr for non-SUNY External & Industry projects
        # Hours requested: __________
    Source of Funding: _______________________________________________________________________

P.I. SIGNATURE: __________________________________      DATE:__________________

IHP MRI COMMITTEE CHAIR APPROVAL, DR. D. FEIGLIN:  ____ Y  ____ N
RESEARCH ADMINISTRATION APPROVAL, DR. S. GOODMAN:  ____ Y  ____ N
Please return completed form to GM Tillapaugh-Fay IHP-MRI Core rm. 1203F.

If needed, comments and/or recommendations will be sent from MRI Core Committee Chair, D. Feiglin, MD
If your request has been denied you may submit a request for review by the committee.

IHP MRI Core Form - MARCH 2011