

# Empire Clinical Research Investigator Program

## Start-Up Report

<b>Program Information (As Reported in the Project Submission)</b>
Project Number (Assigned by DOH):
Hospital:
Hospital Operating Certificate Number:
Hospital Principal Contact: Address:  Phone Number:  Fax Number:  E-mail:
<b>I certify that the information contained in this report is true and accurate and complies with program requirements.</b>
Principal Contact Signature: _____ Date: _____
Project Title:
Sponsor/Mentor: Address:  Phone Number:  Fax Number:  E-mail:
<b>I certify that the information contained in this report is true and accurate and complies with program requirements.</b>
Sponsor/Mentor Signature: _____ Date: _____

**Researcher Information (New Information Requested)**

Name of Research Candidate:

Citizenship Status:

Name of Medical/Dental School Completed, Degree and Date:

Name of Residency Program:

Specialty:

Home Address:

Medical License / Limited Permit Number:

Start Date:

Number of Hours per Week in Research Position:

Name of Institution Review Board (IRB):

Date Project Approved by IRB:

**Supplemental Information (Reference the Question these Changes Pertain to in the Project)**