**Study Cost Estimate Form (Generic)**

**Identify Department Impacted:**

This form must be completed by **each** health service, service delivery unit, or corporate support where costs are generated.

The Principal Investigator is responsible for ensuring that all departments impacted by the study have been properly informed by submitting a copy of the protocol to the appropriate department Health Service/Service Delivery Unit/Corporate Support Leader. This form must be signed by both parties whether there is a cost involved or not. **This ensures that MGH Research Ethics Board (REB) is informed that the proposed impacted departments have been notified, have agreed, and have the resources required to carry out the study**.

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| --- | --- | --- | --- | --- |
| MGH Local Principal Investigator: | |  | | |
| Full Study (Protocol) Title: | |  | | |
| Services | | | Estimated Costs | |
| 1. | Material | | $     .00 |  |
| 2. | Labour | | $     .00 |  |
| 3. | Off-setting Savings | | $     .00 |  |
| 4. | Others: | | $     .00 |  |
| 5. | Others: | | $     .00 |  |
| 6. | Total Fixed Costs | |  | $     .00 |
| Total Cost / Patient | |  | $     .00 |
| Estimated Total Costs | |  | $     .00 |

The       department is prepared to absorb **%** of the estimated costs of this study.

**Note: Any additional costs generated by the study will be assumed by the investigator**

**Additional Notes** (Between Investigator(s) and       department)

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|  |  |  |  |  |
| PRINT Name of Local MGH Principal Investigator |  | Signature |  | Date |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| PRINT Name of Health Service/Service Delivery Unit/Corporate Support Leader |  | Signature |  | Date |

**Submission Instructions:**

**One (1)** electronic copy of this fully completed and signed form is to be submitted with your TAHSN Research Application