**UBMD Orthopaedics & Sports Medicine**

**Medical Student Researcher Form**

**A. Identifying Information**

|  |  |
| --- | --- |
| Last Name | First Name |
| Phone Number | Email Address |
| Year in Medical School (circle one) 1 2 3 4 | |

**B. Research Study is part of the (circle all that apply)**

|  |
| --- |
| UB ORS 950 Course |
| UB Orthopedics Summer Research Program |
| Other (please specify): |

**C. Scope of Research Study**

|  |  |
| --- | --- |
| Study Title: | |
| Type of Study: | |
| IRB Approval Dates: | |
| PI/Co-PI: | PI/Co-PI Email: |
| Research Coordinator: | Research Coordinator Email: |

**Part I: Definition-** A medical student researcher MAY NOT PROVIDE PATIENT CARE. All research must be completed/stored on a UBMD Ortho computer/telephone during office hours. Tasks, including those involving patient contact, &/or patient-related activities are limited to those specifically defined & approved within this form.

**Part II: Supervisory requirements-** All medical student researchers must be supervised by a member of the UBMD Orthopaedics Staff.

**Part III: 1) Core Competencies-** Collect, Collate, & Maintain Data

**2) Patient Interaction-** (List any activities not listed under the core competencies in #1)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **1ST COLUMN TO BE COMPLETED BY APPLICANT // COMPLETED BY SUPERVISOR** | | | | |
| Requesting approval for the above named medical student researcher to participate in the following patient contact &/or patient-related activities |  | Approved | Not approved | With direct supervision |
|  |  |  |  |  |

**Part IV: Supervisor’s Attestation:**  As this medical student researcher’s supervisor I personally attest to the competence of the above applicant with regard to the activities listed in Part III above.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature, Supervisor; \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name, Supervisor; Date\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

**Part V: Medical Student Researcher Attestation: (initial)**

\_\_\_\_\_ I have read/understand the pre-study abstract/proposal associated with the above mentioned study. All of my initial questions have been answered by the research personnel. If I have further questions, I will not hesitate to ask any of the study contacts.

\_\_\_\_\_ I understand that is my responsibility to advise the study coordinator immediately of any new, different, or additional information that brings about concern relating to the study, study procedures, or study personnel.

\_\_\_\_\_ I acknowledge that I am familiar with the principles & standards for Good Clinical Practice and Ethical Principles/Guidelines for the Protection of Human Subjects Research.

\_\_\_\_\_ I acknowledge that I am completing my COVID-19 daily health check and I am/will follow the UB COVID-19 health and safety guidelines.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature, Medical Student Date\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name, Medical Student