

## Request for LDH Support *(to be completed by the PI)*

Project Title: \_\_\_\_\_

Principal Investigator (PI): \_\_\_\_\_

Email Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Affiliation(s): *(be specific)* \_\_\_\_\_

Is this project fully or partially funded by LDH? ☐ Yes ☐ No ☐ Unsure

If yes, state funding name/number and source: \_\_\_\_\_

Is LDH IRB review a funding or program requirement? ☐ Yes ☐ No ☐ Unsure

Support requested from LDH: *(check all that apply)*

- ☐ Data request
- ☐ LDH employees as research participants
- ☐ Recipients of LDH services (eg: Medicaid beneficiaries) as research participants
- ☐ Other

Explain the nature of support you are requesting from LDH (eg: brief description of data requested). [1000 characters]

Provide a brief summary of the project. Must include the following sections: Background, Objective, Implementation (optional), Methods, Analysis Plan, and Potential Impact. [2000 characters]

Briefly explain how the proposed project offers a clear public health benefit and/or aligns with LDH's mission to protect and promote health and to ensure access to medical, preventive and rehabilitative services for all citizens of the State of Louisiana. [1000 characters]

Is there anything else LDH should know while considering your request for support for approval? [500 characters]

## LDH Letter or Memorandum of Support (to be completed by LDH)

**LDH Program Office** (list all involved; eg: OPH, BHSF)      **Bureau/Section/Program** (list all involved; eg: BHI, VR)

**SECTION I:** Please indicate your response to each of the following statements and initial next to your response.

Note: Different people can check and initial each of the items below.

	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<u>Initials</u>
This research project offers a clear benefit to public health and/or supports LDH's mission to protect and promote health and to ensure access to medical, preventive and rehabilitative services for all citizens of the State of Louisiana.	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fulfilling this request is minimally disruptive to daily operations.	<input type="checkbox"/>	<input type="checkbox"/>	_____
This request for LDH to support the research is <b>approved as is</b> .	<input type="checkbox"/>	<input type="checkbox"/>	_____
This request for LDH to support the research <b>requires modifications</b> .	<input type="checkbox"/>	<input type="checkbox"/>	_____

**If research support is NOT approved as is, STOP HERE and inform the researcher of the decision along with any relevant reasons that might help them make appropriate modifications for future consideration.**

**SECTION II** (skip if request is NOT approved): Specify how LDH will support this research project.

- ☐ 1. Access to LDH clinic(s)/facility(ies) specified below for the purpose of search

1a. Name(s) of clinic/facility:

- ☐ 2. Access to LDH employees or recipients of LDH services for research purposes

2a. Explain briefly:

- ☐ 3. Access to LDH data and associated resources (attach list of data elements to be shared, including source)

- ☐ 4. Research guidance and mentorship (e.g.: preceptor to a student researcher)

4a. Name of mentor/preceptor:

- ☐ 5. Other (describe; include attachments as needed):

**LDH point of contact (POC) designated for this project [to help PIs obtain the above noted support].**

Primary POC	Alternate POC
Name:	Name:
Title:	Title:
Email:	Email:
Phone:	Phone:

**SECTION III:** *This document must be signed by ALL Program Managers whose division/bureau/section are directly responsible for providing support for this research project. Depending on internal policies and procedures at your Agency/Clinic/Facility, the document may also need to be signed by one or more higher-level administrator(s), such an appointing authority or their designee, who is authorized and able to make decisions about committing LDH time and resources to support (or not support) research projects and data requests. Please use as many signature lines as needed; leave any unused lines blank. Additional lines may be added if required.*

I concur with the decision points indicated in Sections I and II. However, I understand that the PI is not authorized to begin research activities, receive data or implement modifications to the protocol until written authorization from LDH IRB is received. I agree to suspend research activities and/or data sharing and report to the LDH IRB any unauthorized modifications or instances in which client/patient rights appear to be violated.

Sign:	Name:	Date:
Title & Affiliation:		

Sign:	Name:	Date:
Title & Affiliation:		

Sign:	Name:	Date:
Title & Affiliation:		

Sign:	Name:	Date:
Title & Affiliation:		

Sign:	Name:	Date:
Title & Affiliation:		

*PIs are encouraged to submit applications to LDH IRB concurrently with other institutions' IRBs. Please note, however, that as the IRB of Record, LDH IRB will require decision letters from all other institutions before it can issue a decision.*