Skåne University Hospital (SUS)
Department of Imaging and Functional Medicine
(VO Bild och Funktion - BoF)

Date:

Application for Research Collaboration
Clinical Research Council, Department of Imaging and Functional Medicine (BoF-SUS)

This application is mandatory for all research projects conducted in collaboration with or within Department (VO) of Imaging and Functional medicine (BoF), Skåne University Hospital (SUS). More information about the application procedure can be found at the following address:
https://vard.skane.se/skanes-universitetssjukhus-sus/om-oss/vara-specialistomraden/bild-och-funktion/forskningssamarbete-med-bild-och-funktion/

Please note: Submission of this application does not guarantee approval of the project.
The following document must be submitted to: forskningssamarbete.bf.sus@skane.se

- Application Form (fully completed)
- Modality Appendix (fully completed)
- CTIS/EPM (application + approval (can be supplemented later))
- Study Protocol
- Imaging Guide/Procedure Manual (if available)

Project Title:

BoF Number *(assigned by BoF)*

Date Received *(filled by BoF)*

Requested study site(s):

- ☐ Lund
- ☐ Malmö
- ☐ Trelleborg

Provide complete contact information (name, institution/company, phone, email) **for:**

Principal Investigator (PI)

Research Nurse:

BoF Co-author (if applicable):

Other Contacts:

Desired Modalities/Examinations:

- ☐ CT
- ☐ MRI
- ☐ PET-CT
- ☐ Conventional X-ray
- ☐ Ultrasound
- ☐ Biopsies

Nuclear Medicine-specify:

Clinical Physiology-specify:

Clinical Neurophysiology-specify:

Other Imaging Technique/Examination-specify:

Project Description:

Briefly describe the project's purpose and methodology (maximum 10-15 lines). Attach the Study Protocol and Imaging Guide/Procedure Manual (if available):

CTIS/EMP Application Including Radiation Safety:

Estimated Radiation Dose:

(Our medical physicists can assist if needed -please contact us!)

☐ Not yet submitted

☐ Submitted

Date:

☐ Approved (a copy must be provided BEFORE study start)

Approval date and
reference number:

Start date (planned**) for imaging examinations:**

Completion date (estimated**) of the final examination at BoF:**

I**nclusion/**

Enrollment period:

Funding/Financing Information:
Is there any form of external funding for this project/study?
(External funding includes the Swedish Research Council, foundations, or industrial sponsors.)

☐ No

☐ Yes

If Yes, specify the company/foundation and provide the name, email, and phone number of the contact person:

Billing Contact and Address for Invoice/Faktura:

Is the study funded by a university or other academic institution?

☐ No

☐ Yes

If Yes, specify the institution and contact details: name, email, phone number and contact person:

For internal funding (Region Skåne), specify the department, contact person's name, email, phone number, and account to be charged:

Multicenter Study/Multiple Cites:

☐ No

☐ Yes

Site Number:

Other Sites:

Additional Information:

Notes by the Clinical Research Council: