**Application for Research Acceleration Program Funding**

**(Tier III)**

Carilion Clinic has designated funds for the Research Acceleration Program (RAP) to provide seed money for pilot research projects. This seed funding will enable Carilion faculty to conduct preliminary research in order to develop and enhance pilot projects into competitive candidates for external funding and publication opportunities.

Tier III Applications will be reviewed according to the following criteria:

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| * Significance |
| * Dissemination |
| * Collaboration Building Potential |

The RAP funding cycle is annual. The average project period will be one year, and funds must be spent within that one-year period. The deadline for submitting an application and all supporting documentation will be announced on the Department of Research & Development’s (R&D) webpage and via a general email announcement. The original signed and completed application packet must be delivered to R&D no later than 4:00pm on the due date.

If your project involves any outside person or organization, if funded, your project will require a collaborative agreement, which will be negotiated by R&D and will need to be approved by the VP of Academic Affairs. Should you have any questions about the process, please contact R&D at 540-985-8510, (F) 540-985-9816, or [research@carilionclinic.org](mailto:research@carilionclinic.org).

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| 1. **General Project Information**   **NOTE: Once you enter the application process your project PI & Title MUST remain the same** | | | | | | | | | | | |
| Carilion Principal Investigator/Program Director: | | | | |  | | | | | | |
| Department& Address: | | |  | | | | | | | | |
|  | Telephone: | | |  | | | | Email: | |  | |
|  | | | | | | | | | | | |
| Contact Person (if other than PI): | | | | | | |  | | | | |
|  | Telephone: | | | | | |  | Email: | |  | |
|  | | | | | | | | | | | |
| Project Title: | |  | | | | | | | | | |
| 1. **Co-PI Information** | | | | | | | | | | | |
| Co-Principal Investigator/Program Director: | | | | |  | | | | | | |
| Department& Address: | | |  | | | | | | | | |
|  | Telephone: | | |  | | | | Email: | |  | |
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| **III. Personnel & Time and Monthly Effort on Project of Carilion Employees** | | | | | | | | | | | |
| **Name** | | | | | | **Role &Responsibility** | | | **Percent Effort**\* | | **Signature** |
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| **\*Please enter the total monthly percentage of effort each individual will spend on the duration of the project. As an example, if a full-time investigator will work one day a week on the project, the percent effort would be 20%.** | | | | | | | | | | | |

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| **IV. Non-Carilion Collaborator Contribution, including Students (see details below)** | | | |
| **Name** | **Role &Responsibility** | **Institution** | **In-Kind Contribution** |
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| If your project has any non-Carilion collaborator or team member, including students and faculty from other institutions such as VT (including VTCRI & VA-MD Vet Med), VTCSOM, VCOM, LTC/Nursing facilities, etc. Please include a Letter of Intent and a Statement of Work, which can be downloaded at [here.](http://insidecarilion.org/system/files/Statement_of_Work_SAMPLE.DOC) **NOTE:** Additional agreements may be required. | | | |

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| **V. Required Attachments** |
| The following documents must be attached to this form in order for your application to be considered complete. |

1. **Research Acceleration Application**

Must be complete with all signatures.

1. **Biograhical Sketches of PI and co-PI**Must be in NIH format, no more than 4 pages each.  
   The biosketch form is available on Inside Carilion Research RAP Info and Forms
2. **Completed Budget Request and Justification**

Complete the budget request in Section VII (page 4). Include a justification of each expense in the space provided in Section VIII (page 5).

1. **Completed Project Narrative**

See Section VIII (page 6) for required outline

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| **VI. Signatures & Certification** |

**Your application will not be deemed complete without all appropriate department chair or designee signatures. Once you enter the application process your project PI & Title MUST remain the same.**

**By signing below, PI/PD certifies that:**

1. The information submitted within the application is true, complete and accurate to the best of the PI’s knowledge;
2. Any false, fictitious, or fraudulent statements or claims may subject the PI to criminal, civil, or administrative penalties;
3. The PI agrees to accept responsibility for the scientific conduct of the project and to provide the required progress reports if a grant is awarded as a result of the application;
4. The proposal complies with federal regulations including standards for integrity of research, RFP/ Announcement requirements, and Carilion's Policies and Procedures;
5. The principal investigator, co-investigators, or anyone involved in the sponsored activity is not presently debarred, proposed for debarment, suspended, declared ineligible, or voluntarily excluded from transactions by the federal department, or agency; and are aware of no circumstance invalidating the legal certifications in the proposal to be made on behalf of the Carilion Clinic.

Principal Investigator/PD: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

**By signing below, management certifies that:**

The following have reviewed and approved this application, and by signing, certify that:

1. The proposed activities are appropriate to the research, instruction or public service mission of Carilion;
2. It is believed that the project aligns with Carilion’s organizational values.
3. The necessary resources for the project, including percent of investigator(s) effort and space and/or facilities are committed and/or budgeted in the RAP grant application.

Chair/Vice President/Dean: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_

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| **VII. Requested Budget [not to exceed $2,000]** | | | | |
| Please fill out all applicable areas. Salary funds may be requested for support positions. These include students, Research Coordinators, Statisticians and other support staff. Note that the fringe benefit rate for Carilion staff varies by department; please contact R&D for rates. Additional areas of support include supplies, ancillary services, and subcontractors/consultants. As RAP funds are intended to underwrite research conducted by Carilion medical staff, overhead costs (F&A) will not be included. | | | | |
| **Other Personnel** | | | | |
| ***Name and/or Role*** | ***Percent Time*** | ***Salary Requested*** | ***Associated Fringe Benefits*** | ***Total Request*** |
|  |  |  |  |  |
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|  |  |  |  |  |
| **Other Personnel Total** | | | |  |
| **Materials and Supplies** (Itemize below) | | | |  |
|  | | | |
| **Materials and Supplies Total** | | | |  |
| **Consultant** | | | |  |
|  | | | |
| **Consultant Total** | | | |  |
| **Subcontracting Institution** | | | |  |
|  | | | |
| **Subcontracting Institution Total** | | | |  |
| **Other Expenses** (itemize below) | | | |  |
|  | | | |
| **Other Expenses Total** | | | |  |
|  | | | | |
| **TOTAL REQUEST** | | | |  |

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| **VIII. Budget Justification** |

On this page, justify each of the line items in the budget above. For support personnel, give a description of what their roles will be in the project.

**Personnel**

**Materials and Supplies**

**Consultants**

**Subcontracting Institution**

**Other Expenses (Travel, Equipment, Education, etc)**

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| **IX. Research Topic** |

Carilion Clinic Research Topic

**Carilion Clinic Protocol Template Version Date: 2016**

**Title: {Complete Title of Study}**

**Principal Investigator: {Include credentials, e.g. MD, PhD, MSN, etc. Include mailing address, phone number, and Carilion Department/affiliation, e.g. Department of OB/GYN or JCHS Department}**

**Other Investigators: {List names, credentials and affiliations of other researchers}**

**Study Abstract**

**{Provide a brief, non-technical summary of the research topic/question}**

**Background**

**{Summarize background information about the research topic/question. State why the research topic/ question should be addressed and include the relevance to the organization. Also, provide references to relevant articles in the literature.}**

**Objectives**

**{State expected outcome(s), e.g., education, awareness, collaboration. A primary outcome or objective must be identified. After the statement of the primary objective, secondary objectives may be listed. Objectives should be simple and specific.}**

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| **XIV. Privacy & Information Security Clinical Research Questionnaire** |

**Privacy and Information Security Clinical Research Questionnaire**

Please answer the questions below to describe the plan to protect the data from improper use and disclosure.

## General Information – Study title

## Which HIPAA identifiers will the study team collect?

**INSTRUCTIONS**: Select YES to any item that will be written down/kept/recorded in **any** way that relates to this study.

|  |  |  |
| --- | --- | --- |
| **YES** | **NO** | **HIPAA Identifier** |
|  |  | 1. Name |
|  |  | 2. Postal address information, other than town or city, state, and zip code |
|  |  | 3. Age or Date of Birth if over the age of 89 |
|  |  | 4. Telephone numbers |
|  |  | 5. Fax numbers |
|  |  | 6. Electronic mail addresses |
|  |  | 7. Social Security number |
|  |  | 8. Medical Record number |
|  |  | 9. Health plan beneficiary numbers |
|  |  | 10. Account numbers |
|  |  | 11. Certificate/license numbers |
|  |  | 12. Vehicle identifiers and serial numbers, including license plate numbers |
|  |  | 13. Device identifiers and serial numbers |
|  |  | 14. Web Universal Resource Locators (URLs) |
|  |  | 15. Internet Protocol (IP) address numbers |
|  |  | 16. Biometric identifiers, including finger and voice prints |
|  |  | 17. Full face photographic images and any comparable images |
|  |  | 18. Any other unique identifying number, characteristic, code that is derived from or related to information about the individual (e.g. initials, last 4 digits of Social Security #, mother’s maiden name, first 3 letters of last name.) |
|  |  | 19. Any other information that could be used alone or in combination with other information to identify an individual (*e.g. rare disease, study team or company has access to the health information and a HIPAA identifier or the key to the code*). |

## Will data be collected retrospectively, prospectively or both? If retrospective, what is the timeframe for the data review?

**INSTRUCTIONS:**  Retrospective means that all data has already been collected at the time this protocol is approved by the IRB (e.g. the information is already in medical records).

**Response:**

## How will you collect data?

**IMPORTANT NOTE**: You may **not** store data on a personal device or locally to your workstation. You **may** use a shared drive.

**INSTRUCTIONS:** Please select one of the options below

(i) Record review

(a) What system will be used for the record review?

Epic

Other – Please specify.

(ii) Interviews

(a) How will these interviews be conducted?

In person

Other – please provide details.

(iii) Surveys

(a) How will you conduct the surveys?

Kiosk

Application – Please provide name of the application.

(iv) Surveillance

Video

Audio

## How will you store the data?

**IMPORTANT NOTE**:

- You may **not** store data on a personal device or locally to your workstation. You **may** use a shared drive instead.

- You may **not** store data in an unapproved cloud provider such as Dropbox, Google Drive, Google Docs, etc.

(i) On a Carilion Clinic shared drive

(ii) Storage managed by the sponsor or CRO in which the data will be sent and stored encrypted   
 (a) Please provide the name of the sponsor or CRO:

(iii) Cloud (please see above for unapproved cloud providers)

(a) Please provide the name of the application:

(iv) Paper

(a) What will be stored?

(b) Where will it be stored?

## Data Access

**IMPORTANT NOTE:**

1. You may **not** store HIPAA identifiers with de-identified data.

2. You may **not** store the data key on a personal device or locally to your workstation. You **may** use a shared drive instead.

**INSTRUCTIONS:** If you did not choose YES to any item in question 1 skip this question.

**Response:**

## Who will have access to the data?

**Response:**

## Who will have access to the data key if the data is de-identified?

**Response:**

## How long will you retain the data?

**Response:**

## Do you have a plan to delete the data at the end of the project? If so, please describe.

**Response:**

## How will you share data related to the study with individuals inside Carilion Clinic?

**Response:**

## How will you share data related to the study with individuals outside Carilion Clinic?

**Response:**