**Medical College of Wisconsin Office of Research**

**REQUEST FOR APPROVAL TO COPY DATA - HUMAN RESEARCH**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| PI making request: |  | Phone: |  | Email: |  |

Please acknowledge your agreement by checking both statements below:

|  |  |  |
| --- | --- | --- |
|  |  | I am requesting approval to obtain a copy of data from research performed at MCW upon my departure from the institution. |
|  |  |  |
|  |  | I agree that the original research data obtained while I was employed at MCW, for which I am requesting a copy, will remain with the department in compliance with MCW policy. |
|  |  |  |
| PI signature: |  | Date: |  |

**REQUEST TO COPY DATA FROM THE FOLLOWING STUDY:**
*NOTE: If requesting copies of data from more than one study, please use additional forms.*

|  |  |
| --- | --- |
| PRO #: |  |
|  |  |
| Study Title: |  |
|  |  |
| Outcome of Protocol: |  | Terminated |  | Transferred to another MCW Investigator |
|  |  |  |  |  |
| Description of data to be copied: |
|  |
|  |
| Provide a brief explanation of why you wish to obtain a copy of data from research performed at MCW: |
|  |

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| --- | --- | --- | --- |
| Dept. Chair/Center Director/Supervisor Name: |  | Dept: |  |
|  |  |  |  |
| **Signature of above (REQUIRED):** |  | **Date:** |  |

|  |
| --- |
| Please submit your completed form to:Office of Research FAX: (414) 955-6565 or EMAIL: research@mcw.eduFor questions, call (414) 955-8495. As soon as all approvals have been obtained, the signed form will be returned to you. |

**For use by the Office of Research ONLY** *(sign in order noted here)*:

1. Director, HRPP Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_
2. Associate Provost for Research Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

 cc: HRPP QI Manager