

Grady Health System

Financial Clearance Form

Office of Grant Administration
50 Hurt Plaza, Suite 301
Atlanta, Georgia 30303
grants@gmh.edu

INSTRUCTIONS:

- When requesting Financial Clearance, please type all information requested on this form and submit along with applicable documents to: grants@gmh.edu
- Contact the Office of Grant Administration with any questions at 404.616.5791

Financial Clearance (Include applicable documents identified below):

- | | | |
|---|---|--|
| <input type="checkbox"/> Protocol | <input type="checkbox"/> Informed Consent – Sponsor Draft | <input type="checkbox"/> Drug Study: IND# _____ |
| <input type="checkbox"/> Medicare Coverage Analysis
(Prospective Reimbursement Analysis) | <input type="checkbox"/> Clinical Trial Agreement | <input type="checkbox"/> Device Study: IDE# _____
FDA Approval Letter |

CONTACT INFORMATION:

Requesting Organization: Emory Morehouse Other: _____

Principal Investigator: _____ **E-mail:** _____ **Phone:** _____

Research Coordinator: _____ **E-mail:** _____ **Phone:** _____

STUDY INFORMATION:

Submission Category: New Renewal Modification / Amendment

Full Study Title: _____

Study acronym: _____

IRB#: _____ **IRB Expiration Date:** _____

Sponsor: _____

Funding Source: Federal Foundation Industry Other: _____

Estimated # of Subjects: _____ **Estimated Start Date:** _____ **Length of Study:** _____

Location of Research (Where subjects will be seen):

- | | |
|--|---|
| <input type="checkbox"/> Main Hospital, Room number: _____ | <input type="checkbox"/> Infectious Disease Center / Ponce de Leon Center |
| <input type="checkbox"/> CIN/ACTSI/GCRC | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Neighborhood Clinic | |

Type of Study:

- Clinical Trial
- Survey
- Registry
- Medical Records/ Chart Review
- Other: _____

Will the study require Grady to receive for free or to purchase any patient supplies or equipment from sponsor? Yes No IF YES, please explain: _____

Will the study utilize any Grady staff for items or services not charged with a CPT code, i.e. nursing staff time, etc.? Yes No IF YES, please explain: _____

Will a subcontract or other contractual arrangement be required? Yes No Unknown

Will the study require Pharmacy? Yes No

GRADY DEPARTMENTS INVOLVED:

- Laboratory and Pathology Radiology Pharmacy Cardiology Other: _____

CPT Code	Description	Quantity (Per Subject)	EAP Code (GHS Use Only)	Price per Unit (GHS Use Only)
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