

Application Form

DATE PREPARED:		DATE RECEIVED: (for TRC only)	
TITLE:	PRINCIPLE APPLICANT:		
ORGANIZATION:			
DEPARTMENT/RESEARCH INSTITUTE:			
STREET:		CITY:	
PROVINCE/STATE:		COUNTRY:	
POSTAL/ZIP CODE:		EMAIL:	
PHONE:		FAX:	

PROJECT NAME:
REB SUPPORT REQUEST OR REB APPROVAL NUMBER (if applicable):
REB ORGANIZATION:
BRIEF PROJECT DESCRIPTION:

SAMPLES REQUIRED: (please place 'X')	<input type="checkbox"/> Blood	<input type="checkbox"/> CSF (Cerebrospinal fluid)
	<input type="checkbox"/> Urine	<input type="checkbox"/> BAL (Bronchoalveolar lavage)
	<input type="checkbox"/> Swab/Saliva (DNA)	<input type="checkbox"/> Other

SOP CONCERNS/ACCOMODATIONS:

PROJECTED TIME / SAMPLES NEEDED:

COMPLETED BY: _____ DATE: _____
(for TRC only)