



SITE RESOURCES CHECKLIST

Clinical Trials outside UERMMMCI by Non-UERMMMCI Personnel SELF-ASSESSMENT FORM

DATE: _____

INSTRUCTIONS: Complete this form if you a **non-UERMMMCI** principal investigator applying for ethical clearance from the RIHS ERC for a clinical trial or clinical research that will be conducted outside the UERMMMCI premises. This form is mandatory for the aforementioned investigator-site category. All fields should be completely filled. If necessary, supporting documentation may be required.

Kindly fill out this form accordingly

RIHS ERC Code:	
Principal Investigator	
Contact Number	
External Site	
External Site Address	
Medical Director (External Site)	
Contact Number	
Study Sponsor	
Study Protocol Title	

ERC Form 2G: Site Resources Checklist Non-UERMMMCI PI

	Yes	No	Remarks
1. Does your hospital provide a 24-hr emergency room service?			
2. Does your emergency room have a fully loaded e-cart?			
3. Does your emergency room have a functioning defibrillator?			
4. Does your hospital provide ICU care?			
5. Does your ICU have a functioning cardiac monitor?			
6. Does your ICU have a fully loaded e-cart?			
7. Does your ICU have a functioning defibrillator?			
8. Does your ICU have functioning ventilators?			
9. Do you have an office space in the hospital that is conducive to the conduct of the clinical trial?			
10. Do you have a telephone line?			
11. Do you have a fax machine on 24 hrs?			
12. Will the sponsor be willing to shoulder expenses for monitoring of the study by the RIHS ERC (1 visit per one year duration of study by two RIHS ERC members and 1 Staff doing the site visit)?			
13. Is your hospital administrator willing to have a Memorandum of Agreement (MOA) with UERMMMCI regarding the review of the study protocol and monitoring of the conduct of study by RIHS ERC?			
14. Where do you plan to recruit your research participants?	<name of site>		
15. How many patients with the condition of interest do you see per month in your clinic/hospital?	<quantity>		

PRINCIPAL INVESTIGATOR	Name	
Date:	Signature	
ADMINISTRATOR¹	Name	
Date:	Signature	

¹ Signatory official for clinic or hospital