 Human Research Protections Program

McLaren Health Care

2701 Cambridge Ct., Suite 110

Auburn Hills, MI 48326

Phone: (248) 484-4950

Fax: (248) 276-9732

e-mail [hrpp@mclaren.org](mailto:hrpp@mclaren.org)

**PROJECT IMPACT STATEMENT**

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| *This form may be duplicated as needed.*  **Researcher/Principal Investigator:**  Identify any department (e.g. Medical Records, Pharmacy, Laboratory, Nursing, Finance, Radiology, Surgery, etc.) of your subsidiary hospital that will be affected by this research and obtain the Department Manager/Director’s written approval.  You must provide this signed statement to the MHC IRB Office either by mail:  2701 Cambridge Ct., Suite 110  Auburn Hills, MI 48326  OR Fax: (248) 276-9732  MHC IRB Approval letter will not be issued until MHC IRB office receives a signed copy.  **Department Manager/Director:**  *Be sure you have a clear understanding of the role(s) your department plays in this research project, and the reimbursement of expenses, if applicable.*  You may request that the researcher provide you with documentation of the outcome of the MHC IRB’s review *before* the project is initiated in your department. |

**Department Manager/Director**

I have reviewed the project, entitled <insert full title>, with <insert PI name> (the researcher/PI) or his/her designee and I confirm the following **(please place a check mark in the boxes as confirmation that each item has been addressed):**

☐ We discussed the impact this project will have on this department.

☐ I have reviewed research procedures pertaining to this department with the PI or his/her designee.

☐ I understand the financial impact the research procedures may have on this department.

☐ I have been provided with a copy of this form for future reference.

**Approved by:**

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**Signature of Department Manager/Director granting approval** **Date**

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**Printed name of Department Manager/Director**

<insert department name> McLaren - <insert subsidiary name>

**Department McLaren Subsidiary**