**Bwindi Community Hospital Research Proposal form**

**Details of Principal Investigator:**

Name: Answer

Institution and Department: Answer

Job title/role: Answer

Email: Answer

Website if available: Answer

Telephone: Answer

**Details of proposed research:**

* Study title: Answer
* Study team members: Answer
* Status of study: Funded *(please give details)* / Proposed study / Masters; PhD; Other studentship. Answer
* Brief summary of study: *(Please include objectives, methods, anticipated number of subjects, anticipated study duration, etc. What will individual participants be required to do? If a protocol or written proposal is available please include it.)* Answer
* Proposed study dates: *(If there is a specific time that you need to do the study, please specify)* Answer

**Ethics:**

* Does the study already have IRB approval? Yes / No / Not required *(Please give details – which IRB(s) have you applied to/do you plan to apply to? If you have already applied, please list dates of application and approval. If you feel that ethical approval is not required, please describe rationale for this below.)* Answer
* Please summarise proposed arrangements for consent*:* Answer
* Have you identified any ethical issues that need further consideration? Answer

**Science:**

* Why is this an important/relevant research question? Answer
* Why do you want to do this research at BCH, specifically? *(If you already have an affiliation with BCH, please state that here.)* Answer

**Benefit:**

* How will this study benefit the patients of BCH, either directly or indirectly? Answer
* How will this study benefit the Hospital, either directly or indirectly? Answer

**Information governance:**

* Please describe arrangements to ensure confidentiality, data security and access to data:

Answer

**BCH staff contributions and health:**

* Please describe what contributions will be needed from BCH staff. *(How much time is this likely to require?  What training will be provided?  Are there any risks to BCH staff?)* Answer

**Language:**

* What translation needs do you have in preparation for the study (i.e. translation of study materials)? Answer
* What translation needs will you have during the study (i.e. obtaining consent, interviews, focus group discussions)? *(Please be as specific as possible – for example if you anticipate needing a translator for 2 hours each day, please state so.)* Answer
* What translation needs will you have after the conclusion of the study (i.e. reviewing interview transcripts)? Answer

**Intellectual Property**

* Please describe your plan to share the study findings with the Hospital. *(This plan must include, at minimum, the submission of a brief written report summarizing the results and conclusions of the study within 6 months of project completion.)* Answer

**Budget:**

* Research Fee (*Please mark the appropriate category. The research fee must be submitted prior to initiation of the study.)*

Ugandan Principal Investigator:

* Individual or Team ≤ 5 people and project ≤ 3 months: 50 USD
* Organization or project > 3months: 200 USD

Discount of 50% applies in if there is co-authorship with BCH staff.

Undergraduate students will be not required to pay.

Non-Ugandan Principal Investigator:

* Individual or Team ≤ 5 people and project ≤ 3 months: 200 USD
* Organization or Team > 5 people or project > 3 months: 600 USD

Discount of 50% applies in if there is co-authorship with BCH staff.  Undergraduate students will be required to pay 50 USD

* On-site resource needs *(Please list* ***BCH resources*** *you propose to utilize. These will be charged at the conclusion of the study. A list of estimated costs and mode of payment will be supplied to you in response to this application.)*
	+ Staff time: Answer
	+ Clinical supplies: Answer
	+ Office supplies: Answer
	+ Translation needs (please estimate # hours): Answer
	+ Transport (please estimate distance): Answer

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Please complete this form as fully as possible and submit to the PA to the Executive Director: patomsbwindihospital@gmail.com and researchbwindihospital@gmail.com

**Appendix 1: Data Confidentiality Agreement**

**Bwindi Community Hospital Data Confidentiality Agreement**

 I, the undersigned, agree to the following:

 All information shall be treated as strictly confidential and shall not be disclosed or provided to any company, employee, contractor, or other third party who has not signed a Data Confidentiality Agreement. In addition, access to such data shall be allowed only if necessary in the performance of that persons work responsibilities. All other access must be authorized in writing. In addition:

1. No attempt shall be made to identify any individual or other personally identifiable information contained in such records.
2. No data that identifies specific individuals or other personally identifiable information may be accessed or shared with any other party.
3. No aggregate data from such records shall be reported or published without written permission of the executive director or PHA.
4. Data may not be copied or stored in any format outside of approved backup procedures.
5. Software Developers may not copy data for development and testing purposes without the written permission of the executive director or PHA.
6. Access to production, acceptance test, and development data, shall be protected in accordance with the requirements of the data controller.
7. Any breach, or suspected breach, of data confidentiality shall be reported immediately to the data controller.

Violation of this agreement may be the basis for legal penalties or data access rights may be withdrawn.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Signature)

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Date)

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Print Name)

For the purposes of this document, the assigned data controller is:

  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Osbert Magara/Agwokutho Jimmy

IT Technician

Bwindi Community Hospital

**Appendix 2: Data Requisition form**

**BWINDI COMMUNITY HOSPITAL**

**Data Requisition form**

 Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ eMail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Company/Organization:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Job Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Description of the Data, why you need it and for what purpose?

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 Access End Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 All expected user groups for the data requested (i.e. will the data be released to third parties?)

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 Place of data analysis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_            Date of data analysis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature) (Date)

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 **BCH USE ONLY**

 Authorized by:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_                            \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Signature)                                                                     (Date)

Executive Director/Principal Hospital Administrator

*on behalf of Bwindi Community Hospital*