Form 2 - Application for Clinical Research Unit Services
Signature Page

Application Completed & Submitted By: _____

Responsibility for Scientific Conduct:
I attest the information provided in this application is current and accurate. In addition, I confirm that:

- I will adhere to the FAU Division of Research Policies and Clinical Research Unit Standard Operating Procedures.
- I will ensure that all personnel from my staff who utilize the Clinical Research Unit complete the required training.
- I will ensure that the study is conducted as approved by the IRB.
- I will provide the Clinical Research Unit with amendments, continuing approvals, and other reports and updated documents in a timely manner.
- I will report adverse events to the Clinical Research Unit and/or the IRB within the required time frames.

Principal Investigator Name (PRINT): _____

Principal Investigator Signature: _____

Date: _____

Responsibility for Medical Oversight (if applicable):
As oversight physician, I confirm that:

- I will supervise and accept responsibility for medical oversight for this protocol.
- I will accept responsibility for the safety of the human subjects enrolled under this protocol.
- I will ensure that all subjects meet eligibility criteria.
- I will report adverse events to the Clinical Research Unit and/or the IRB of record.

Medical Oversight Physician Name (PRINT): _____

Medical Oversight Physician Signature: _____

Date: _____