



Legal Services Department  
Institutional Review Board  
Phone: (716) 821-4477  
Fax: (716) 821-4465

IRB COST ANALYSIS WORKSHEET

Site(s) Applicable to:

[Empty box for site(s) applicable to]

**COMPLETE ALL QUESTIONS**

**Title of Project** (as it appears on the Protocol **AND** Consenting Documents):  
[Empty box for title of project]

**Principal Investigator(s)** (as it/they appear(s) on the Protocol **AND** Consenting Documents):  
[Empty box for principal investigator(s)]

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

Sponsor Contact Name and Number: \_\_\_\_\_

Description of Procedure or Therapy: \_\_\_\_\_

Is this an alternative to a current hospital based procedure or service? If so please specify the procedure it will be replacing:  
\_\_\_\_\_

Anticipated Annual Volume: \_\_\_\_\_ inpatients \_\_\_\_\_ outpatients

Anticipated Length of Stay: \_\_\_\_\_ med/surg floor \_\_\_\_\_ ICU

ICD- 10 Procedure Code(s):  
\_\_\_\_\_

CPT Procedure Code(s):  
\_\_\_\_\_

**FDA Approved:**    Yes                    No                    Other/Notes: \_\_\_\_\_

Please specify unreimbursed costs which will be incurred above and beyond current therapy options by participation in this study:

	Item(s)	Estimated Cost	Frequency	Total:
Patient	_____	_____	x _____	_____
	_____	_____	x _____	_____
Hospital	_____	_____	x _____	_____
	_____	_____	x _____	_____
Investigator	_____	_____	x _____	_____
Sponsor	_____	_____	x _____	_____

Will the sponsor or vendor be responsible for the payment of non-covered services to the hospital? \_\_\_\_\_

If yes, please specify the address that bills are to be submitted to and any special instructions:

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

Are you as an investigator making a profit by participating as an investigator of this study?    Yes                    No

If you have answered yes to the above question, please estimate the amount of your profit: \$\_\_\_\_\_

**Please attach an itemized budget sheet for review by our finance department for funded studies. Please forward contracts to the IRB for legal review.**

Principal Investigator's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Co- Investigator's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

For questions relating to the completion of this form please contact IRB Administrator at 716-821-4477.