### Section A: To be completed by Principal Investigator/Project Coordinator

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Service Department: | |  | | | | Principal Investigator | | |  | | | |
| ERM Number (5 or 6-digits): | | | RMH- | | | RMH Local Project No: (i.e.2020.999) | | | |  | | |
| Short Project Title: | |  | | | | | | | | | | |
| Is this a commercially sponsored clinical trial? | | | | Yes  No | | | | Estimated number of participants: | | | |  |
| Provide a brief description of service requested or reference the page/section in the protocol | | | |  | | | | | | | | |
| Does the study involve using a genetically modified organism (GMO)? | | | | | | | | | | | Yes  No | |
| If Yes, has the service department been provided information and procedures for all GMO specific study requirements? | | | | | | | | | | | Yes  No | |
| Protocol No.: |  | | | | Version: | |  | | Date: | |  | |
| ***I confirm that I have supplied the above service department with the most recent version of the protocol*** | | | | | | | | | | | | |

#### Payment options – Select one option only

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | Charge to RMH cost centre: | | |  | | |
|  | Provide billing details: | Contact Name | |  | | |
| Company Name | |  | | |
| Billing Address | |  | | |
| Name of Contact Requesting SOA: | | |  | | Date: |  |

### Section B: To be completed by the Head or Nominee of the Service Department

|  |  |  |
| --- | --- | --- |
| C:\Users\kresoa\AppData\Local\Microsoft\Windows\Temporary Internet Files\Content.IE5\73C6BP9J\attention-307030_640[1].png | Enter the date that this SOA was received by the Service Department.  *SOAs to be completed within 7 days for commercially sponsored clinical trials and within 14 days for all other projects.* |  |

I have reviewed and discussed the study protocol and applicable project documentation *with the principal researcher or their delegate* and confirm that this department:

|  |  |
| --- | --- |
|  | * Is able to do the investigations indicated with the present resources of the Department |
|  | * Is unable to do the investigations within the present resources of the Department but would be willing to undertake them with financial assistance as specified below: |
|  |  |
|  | * Is unable to undertake the investigations on the following grounds: |
|  |  |
|  | In signing this form, I declare that I am aware of the principles espoused in and the obligations imposed by the ***Australian Code for the Responsible Conduct of Research (2018)*** and its associated guide documents. In particular, I acknowledge the importance of the responsible management of research data. |

#### Nominate Cost Centre for Credit

|  |  |
| --- | --- |
| Service Department cost centre to be credited: |  |

#### Signature – Head of Service Department or Delegate

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Name (Please print): |  | | Position: |  | | |
| Signature *(e- signatures accepted)*: | |  | | | Date: |  |