**Study Restart Capability Form**

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| **Research Details** | | | | | | | | | | | | | | |
| **Short title** |  | | | | | | | | | | | | | |
| **R&D ref** |  | | | | | **IRAS ref** |  | | | | **Priority** | | Choose Priority | |
| **PI** |  | | | | | | **Delivery Team** | | | | Select Team. | | | |
| **Proposed Restart Date** | Click to enter date. | | | | | | **Confirm Study End Date** | | | | Click to enter date. | | | |
| **Confirmation of Support Department** | | | | | | | | | | | | | | |
| Is there sufficient nursing support available to restart this study? | | | | | | | | | | | | | | Choose an item. |
| Is there sufficient study coordination support available to restart this study? | | | | | | | | | | | | | | Choose an item. |
| Is there sufficient data management support available to restart this study? | | | | | | | | | | | | | | Choose an item. |
| **Does this Study require support department involvement?**  *If no support departments are required please move on to sponsor section.* | | | | | | | | | | | | | | Choose an item. |
| **Support Department** | | | **Select** | | **Confirmation of continued support provided by** | | | | **Email** | | | | | **Date confirmed** |
| Pharmacy | | |  | | Enter name of person. | | | | Enter email address. | | | | | Click to enter date. |
| Pharmacy Production Unit | | |  | | Enter name of person. | | | | Enter email address. | | | | | Click to enter date. |
| Cellular Therapies | | |  | | Enter name of person. | | | | Enter email address. | | | | | Click to enter date. |
| Radiology | | |  | | Enter name of person. | | | | Enter email address. | | | | | Click to enter date. |
| Neuroradiology | | |  | | Enter name of person. | | | | Enter email address. | | | | | Click to enter date. |
| Echocardiography | | |  | | Enter name of person. | | | | Enter email address. | | | | | Click to enter date. |
| Labs | | |  | | Enter name of person. | | | | Enter email address. | | | | | Click to enter date. |
| Other  Name of Department | | |  | | Enter name of person. | | | | Enter email address. | | | | | Click to enter date. |
| **Sponsor Confirmation** | | | | | | | | | | | | | | |
| **Sponsor** | | | | **Confirmation provided by** | | | | **Email** | | | | **Date confirmed** | | |
| Enter name of Sponsor | | | | Enter name of person. | | | | Enter email address. | | | | Click to enter date. | | |
| **Amendments** | | | | | | | | | | | | | | |
| Has sponsor provided any amendments in relation to this study since its suspension due to COVID-19? | | | | | | | | | | | | Choose an item. | | |
| **If Yes has this amendment been processed as per the R&D amendments process?** | | | | | | | | | | | | Choose an item. | | |
| **DECLARATION:** | | | | | | | | | | | | | | |
| I confirm that the information provided above is accurate, the appropriate support departments and sponsor have been contacted providing confirmation that this study can restart. I confirm that careful consideration has been given to national guidance on social distancing ensuring patient and staff safety, with careful consideration to those patient groups who are considered extremely vulnerable to COVID-19 and are shielding. | | | | | | | | | | | | | | |
| **Principal Investigator** | | Click here to enter text. | | | | | | | | **Date:** | | Click to enter date. | | |
| **Team Lead** | | Click here to enter text. | | | | | | | | **Date:** | | Click to enter date. | | |
| **Research Clinical Lead** | | Click here to enter text. | | | | | | | | **Date:** | | Click to enter date. | | |

\*Please note we do not require wet signatures.

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| **FOR NJRO USE ONLY:** | | | |
| **R&D Officer Review** | Click here to enter text. | **Date:** | Click to enter date. |
| **Confirmation email sent by** | Click here to enter text. | **Date:** | Click to enter date. |
| **Notes** |  | | |