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| **Date Last reviewed** |  |
| **Date Last revised** |  |

Please review the information below. If you have any questions, please contact Risk Management & Insurance at riskmgmt@ucalgary.ca or 403-220-5847.

**Request for International Clinical Trial Insurance
Checklist**

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| 1. **Title of Research Project**
 |  |
| 1. **Country/countries where human clinical trial will be conducted**
 |
| Site | Country | Address | Number of participants on site | Percentage on placebo |
| Site 1 |  |  |  |  |
| Phone: Fax: Email:  |
| Site 2 |  |  |  |  |
| Phone: Fax: Email:  |
| Site | Country | Address | Number of participants on site | Percentage on placebo |
| Site 3 |  |  |  |  |
| Phone: Fax: Email:  |
| Site 4 |  |  |  |  |
| Phone: Fax: Email:  |
| Site 5 |  |  |  |  |
| Phone: Fax: Email:  |
| Site | Country | Address | Number of participants on site | Percentage on placebo |
| Site 6 |  |  |  |  |
| Phone: Fax: Email:  |
| Site 7 |  |  |  |  |
| Phone: Fax: Email:  |
| 1. **Phases of Trial**
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| Phase 1 |  |
| Phase 2 |  |
| Phase 3 |  |
| Expected start date of trial outside of Canada(date enrolment of first trial participant) |  |
| Expected length of trial | Months  | Years  |
| 1. **Name of drug or medical product being tested**
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| Study/protocol name | Title in English | Title in local language |
| 1. **Protocol number**
 |  |
| 1. **Principal Investigator**

UofC Principal Investigator  |
| Name | Title | Department/Faculty | Campus Address |
| Phone:  Fax:  Email:  |
| Local Principal Investigator in country of clinical trial |
| Name | Title | Department/Faculty | Campus Address |
| Phone:  Fax:  Email:  |
| 1. **Local Lead Investigators in country of clinical trial**
 |
| Name | Title | Department/Faculty | Campus Address |
| Phone:  Fax:  Email:  |
| Name | Title | Department/Faculty | Campus Address |
| Phone:  Fax:  Email:  |
| Name | Title | Department/Faculty | Campus Address |
| Phone:  Fax:  Email:  |
| Name | Title | Department/Faculty | Campus Address |
| Phone:  Fax:  Email:  |
| 1. **Documentation**
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| Attach copy of the following documents: Protocol  Informed Consent  Draft Agreements, if any   |
| If there is already a clinical trial policy in place for the trial in this particular country, attach a copy of the existing policy or at a minimum, supply the policy number, policy expiration date and insurer |
| Attached copy | Policy number | Expiry date | Insurer |
| 1. **Company supplying equipment or pharmaceutical**
 |
| Name: | Address:  | Phone:  Fax:  Email:   |
| 1. **Contracts with other parties that will be part of this Clinical Trial:**
 |
| Name of party: | Role: |
| 1. **Comments:**
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