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| **mri_art_small** | **UIC** | **The University of Illinois**  **At Chicago** |
| **Center for MR Research**  **Budget Preparation** | |

This Budget Preparation and the Resource Agreement must be completed before any PAF is signed by the CMRR Director. Fill in all information and check appropriate item boxes. Return this preparation form with research proposal and supporting documentation (5 page proposal or less, without bibliography, to include hypothesis, imaging protocol and how the imaging data are to be analyzed, and IRB approval letter or animal subcommittee approval letter) to Mike Flannery, Email: [mpflanne@uic.edu](mailto:mpflanne@uic.edu).

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| --- | --- | --- | --- |
| Principal Investigator: | | | Date: |
| Investigator’s Title: | | | Department: |
| Office Address: | | | |
| Telephone:    -   - | | Fax:    -   - | E-mail: |
| Title of Project: | | | |
| Funding Source: | | | Submission Date: |
| Start Date: | End Date: | | Funds: Pending  Awarded |
|  |  | | Project Code: |

**MR Imaging Time Requested (smallest unit is 1 hour)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | 3.0T all hours | | | |
| Year | # Hrs per  Session | # Exams  per year | MRI | Spectro |
| 1 |  |  |  |  |
| 2 |  |  |  |  |
| 3 |  |  |  |  |
| 4 |  |  |  |  |
| 5 |  |  |  |  |

Please note that CMRR faculty cannot appear on grant applications as unpaid consultants. Effort must be recognized as a % effort with appropriate salary support.

**Human Procedures**

Patients (Yes/No):     # per year:      Volunteers (Yes/No):     # per year:

**Human Subjects IRB Approval**: Pending: Awarded:  Approval Date:      IRB #:

**(Please attach entire IRB application or approval letter)**

**Animal Studies IACUC Approval**: Pending:  Awarded:  Approval Date:      IACUC #:

**(Please attach IACUC application or approval letter)**

**Supplies** (***can be provided by Center for MR Research but charged to PI)***

IV lines:

Contrast Agent (Y/N):    # doses per exam:       (Agent determined by UIC Central Pharmacy)

Sedation Drugs (Y/N):    Type: **Oral**:  **Intravenous**:  # subjects per year:

Name medication(s) requested: