

	Office of Sponsor and Regulatory Oversight	Document #: <b>F05-202-S01</b>
	<b>Cost Estimation Request for CCR Sponsored Studies</b>	Revision #: <b>1</b>
		Effective Date: <b>22DEC2020</b>

Provide all of the below information in the space provided.

Protocol Number  
(alternative identifier if no number assigned): \_\_\_\_\_

Protocol Full Title: \_\_\_\_\_

Protocol Version (Date): \_\_\_\_\_

Study Phase: \_\_\_\_\_

Principal Investigator: \_\_\_\_\_

CCR Branch: \_\_\_\_\_

Projected Number of Participants: \_\_\_\_\_

Number of Study Visits for each Participant  
per Protocol: \_\_\_\_\_

Number of Sites: \_\_\_\_\_

Active Enrollment Period (in years): \_\_\_\_\_

Total Duration of Study (in years): \_\_\_\_\_

Form completed by:

Sign: \_\_\_\_\_

Name:

Title: