The Regional Medical Center at Memphis

**NAME OF PROJECT:** OFFICE OF MEDICAL RESEARCH

# REQUEST for RESEARCH RATES

**IRB # :** _____

**Project Sponsor:** _____ **Anticipated Start Date:**

**Principal Investigator:** _____ **Phone:** _____

**Study Coordinator:** _____ **Phone:** _____

| Item # | TESTS OR PROCEDURES REQUESTED | Approved Research Rate | CPT Code # |
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**APPROXIMATE NUMBER OF SUBJECTS TO BE ENROLLED:** _____

**Request prepared by:** _____ **Date:** _____

**Rates approved by:** _____ **Date:** _____

The Regional Medical Center at Memphis

## OFFICE OF MEDICAL RESEARCH

# REQUEST for RESEARCH RATES

| Mnemonic Code # |
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