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**Project Proposal Form**

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| **Project information** |
| Date: |  |
| Project Title:  |  |
| Principal Investigator: | *Name of the principal investigator (PI), including academic title* |
| Email: |  |
| Phone: |  |
| Co-Investigator(s): | *Name of the co-investigators, including academic title (add additional fields if more than 1)* |
| Contact Person: | *Name of the project lead or other contact person, including academic title* |
| Email: |  |
| Phone: |  |
| Project description: | *Brief description of the project including goals, population, brain areas of interest, … (max 300 words)* |
| Hypotheses:(optional) | *Hypotheses and/or expected results (not more than 50-100 words)* |
| Data analysis methods:(optional) | *Brief description of analyses (main analysis + additional/exploratory analyses)* |
| **Funding** |
| Charge details: |

|  |
| --- |
| [x]  Existing grant funding (please specify below)[x]  New grant application[x]  Commercial funding[x]  PhD studentship[x]  Internally funded (e.g., start-up, RIF, scanner credits) |

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| Funder and grant title (if any): |  |
| Contact Person: | *Name of contact person, e-mail, and phone number if different from PI* |
| **Ethics**  |
| Approval No.: | *Ethics approval number at your institution (if known)* |
| Approval Date:  |  |
| Expiration Date: |  |
| **Scanner** |
| No. of hours requested: | *Total number of hours requested for the project (including piloting)* |
| Scan duration: | *Expected duration of each scan (hours)* |
| No. of participants: | *Expected number of participants* |
| No. of scans: | *Expected number of scans* |
| Project duration: | *Estimated dates of start and end of the project (MM/YY – MM/YY)* |
| Out of hours scanning: | *Indicate whether any scanning will take place out of hours (evenings and weekends)* |
| **Operators** |
| Will you require an Authorised Person (AP) to operate the scanner: |

|  |  |
| --- | --- |
| [ ]  No | [x]  Yes |

 |
| Other operators  | *Add name and contact information of other operators. Please also indicate whether any further training is necessary for members of the research team*  |
| Testing Special population: |

|  |  |
| --- | --- |
| [x]  No | [x]  Yes [x]  Children [x]  Patients [x]  Other |

*If you need to test any special population, please describe the population of interests (e.g., age, patient type) HERE.* |
| **Equipment & Protocols** |
| Equipment: | ***CUBIC***

|  |  |
| --- | --- |
|  Stimulus PC |  Optical microphone\* |
|  Projector |  Airpuff\* |
|  Response box right hand |  Biopac\* |
|  Response box left hand |  Noise cancelling headphones\* |
|  Headphones |  Other, please specify: |
|  Eye-tracker\* |  |

*\* RHUL-owned equipment – can only be used following agreement with RHUL owner. Please contact Ari who will liaise with RHUL staff.* ***Non-CUBIC***

|  |  |
| --- | --- |
|  Laptop |  other equipment |

*If your experiment requires equipment not provided by CUBIC, please briefly describe the equipment HERE. Only CUBIC-certified equipment can enter the scanner room (MRI-safe label is not sufficient). Please contact Ari for obtaining approval and conducting necessary checks* |
| MRI sequences: |

|  |  |
| --- | --- |
| [x]  2D EPI | [x]  ASL |
| [x]  Multiband | [x]  DTI |
| [x]  Field map | [x]  MRS |
| [x]  MPRAGE | [x]  Other |

*Please specify the sequences that you need if not listed here, please indicate whether the sequences need to be required from another centre (it might take some time). Also indicate if you would like to pilot new sequences not covered above. Provide as much detail as possible and include any relevant references.*  |
| MRI parameters (optional): | *Please specify key parameters (e.g., TR, voxel size, number of slices, FOV). Note, these may change following piloting/optimisation.*  |
| Risk Assessment: |

|  |  |
| --- | --- |
| [x]  Not Required | [x]  Required |

*If any non-CUBIC equipment is required for scanning or if a non-standard procedure is used, a risk assessment form must be filled in.* |
| Do you have prior experience/expertise using the methods in this project? |

|  |  |
| --- | --- |
| [x]  Yes | [x]  No |

*RHUL users only: If your project involves methods that you have not used previously, you will be required to present your project at the CUBIC Monthly Meeting prior to approval (though this is recommended for all new projects).*  |

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**For CUBIC technical staff use only**

[x]  Check if project needs to be presented at MRI Users Meeting prior to approval

[x]  Check if presentation completed and feedback acted on

**Project signed off by MRI technician**

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Name (printed) Signature

**Project signed off by CUBIC director / Deputy director**

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Name (printed) Signature