LOI Coversheet
CRI Clinical Innovator Grant

Principal Investigator:

Prefix	First Name	M.I.	Last Name	Suffix

Institution Name: _____

Study Information:

Study Title: _____

_____

IND Sponsor: _____

Trial Phase: _____ **If a hybrid phase, please list:** _____

Protocol IRB Approval Status: _____ **IND Approval Status:** _____

Indications:		**Interventions:** *List drugs and drug access status (e.g. commercially available, drug access secured, to be secured, etc.)*	

Site(s):		**Collaborators:** *If any*	

Study Timing:

Estimated Trial Activation Date: _____ *Month/Day/Year* **Requested Duration of Support:** _____ *No. of Years*

Estimated First Patient, First Visit: _____ *Month/Day/Year* **Estimated Last Patient, Last Visit** _____ *Month/Day/Year*

Financial Information:

Total Study Cost: _____ **Estimated Clinical Budget:** _____ **Estimated Correlative Budget:** _____

Additional Funding Sources (if applicable):

Source	Amount	Funding Status