**Family Health Centers of San Diego**
**RESEARCH INTEREST FORM**

Date:

Organization:

Name & Contact Information:

Title of Study or Opportunity:

Aim(s) or Focus Areas (if

Aims not yet identified:

Intervention(s):

Funded: ◯ YES ◯ NO Award Amount or Cap:

Timeline of study:

Deadline for participation:

What do you need from FHCSD? Letter of Interest, Full Support for Grant application, or other:

Will the study require the following?

- ☐ Use of FHCSD clinic space:
- ☐ Use of FHCSD employees:
- ☐ Use of FHCSD data:
- ☐ Recruiting patients:
  - Will patients be compensated?

How is this partnership beneficial to FHCSD?

INTERNAL STAFF USE ONLY

Date Received:
Date Reviewed:
Research Committee Recommendations:
Provider Champion Identified:
Clinic Location Identified:
Forward to CEO:

Return proposal request and supplemental information to the Department of Population Health pophealth@fhcsd.org