**Instructions**

**Office Use Only**

Date Rec’d:

|  |
| --- |
| 1. Complete this form as thoroughly as you can with responses directed to a general audience.
2. Submit the completed form as indicated below:
* For research projects: Email the form to research@cvmc.us
* For EBP and quality improvement projects: Email the form to ebp@cvmc.us

*You will be contacted for an appointment or appropriate next steps.* |

**Contact Information**

|  |  |
| --- | --- |
| **Name:**  | **Date:**  |
| **Email:** | **Phone:**  |
| **Dept/Practice:** | **Supervisor:** |

*Please respond to the following questions as completely as you can:*

**Activity Type(s)**

|  |  |  |
| --- | --- | --- |
| **What type of activity are you proposing?** (Select all that apply.) | [ ] Research[ ] Evidence-Based Practice[ ] Quality Improvement | [ ] Education[ ] Operations[ ] Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Project Summary**

|  |  |
| --- | --- |
| **Describe the project idea.** * What will you do?
* Where?
* With whom?
* And MOST IMPORTANT: Why?
 | Click here to enter text. |

**Descriptive Keywords**

|  |  |
| --- | --- |
| **What keywords describe the project?** Provide both broad and specific terms and keyword phrases. For instance: “Nursing Heparin Protocol,” “Lab Operational Procedure,” etc. | Click here to enter text. |

**Project Description**

|  |  |
| --- | --- |
| **Problem/Need?**Describe the specific need, issue, or question the project will address.  | Click here to enter text. |
| **Goals & Objectives?**What do you hypothesize the project impact will be? What specific changes do you expect to make in the organization or among the beneficiaries as a result of this project? | Click here to enter text. |
| **Actions?**What major steps will need to be taken to make the proposed changes happen? | Click here to enter text. |
| **Beneficiaries?**Identify and describe the individuals and/or groups who may benefit, either directly or indirectly, from your efforts.  | [ ] Clinical staff[ ] Non-clinical staff[ ] Current patients[ ] Future patients | [ ] Department/Practice[ ] Discipline(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ] Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_[ ] Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Alignment with CVMC Goals?**Identify the organizational goal(s) served by this project. | Click here to enter text. |

**Start Date and Length of Project**

|  |  |
| --- | --- |
| **Timing and Project Length:*** When would the project begin?
* How long do you predict the project will take?
* Is the project time sensitive?
 | Click here to enter text. |

**Resources and Budget**

|  |  |
| --- | --- |
| **What resources will be needed to accomplish the project goals?** *(Staffing, equipment, training, materials, supplies, services, etc.)* | Click here to enter text. |
| **What is the estimated total funding needed for project?**Is there a helpful smaller amount that could start your project and still make an impact?  | **$\_\_\_\_\_\_\_\_\_\_\_ Estimated total project budget****$\_\_\_\_\_\_\_\_**\_\_\_ **Smaller “starter” amount?** |
| **Do you have any funding sources already in mind?** If no funding is required, state NA. | Click here to enter text. |
| **Are there any potential collaborative partners for this project?** Consider possibilities within your own unit/department/practice, others within the organization, community, and/or state, etc. | Click here to enter text. |
|  |
| **FOR OFFICE USE ONLY**Project Decision: [ ] Approved [ ] Denied |
| Organizational Signature: | Date: |