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Medical College

Citigroup Biomedical Imaging Center
1300 York Avenue - Box 234
New York, NY 10021

Citigroup Biomedical Imaging Core User Form – MRI

General Information

Principal Investigator: _____ Dept. / Div.: _____

Phone: _____ Fax: _____ Email: _____

WMC IRB Protocol #: _____ Human Subject Certification #: _____

Protocol Title: _____

Billing Information:

WMC Account #: _____ Account Expiration Date: _____

Billing Address: _____

Imaging Protocol Description:

Subject Name: _____ Date: _____

Study Authorization Signature: _____

Are you requesting to operate 3.0 T MRI Scanner independently? Yes No

Will there be any new devices that are introduced to the CBIC? Yes No

If Yes, please explain: _____

In addition to completing this form, please provide a copy of the following information:

1. Signed IRB approved and stamped consent form for all research subjects being scanned.

Please return form to: **Muc Du**, Box 234 (Room S-260A) or Fax to 746-6681. Any questions regarding form, please call Muc Du at 746-5883.