**W. Martin Smith Interdisciplinary**

**Patient Safety Awards Program**

**SUBMISSION FORM**

Please email this completed form to SIPSmith@sip.ufl.edu

**PROJECT TITLE:**

**PRINCIPAL INVESTIGATOR INFORMATION:**

Name/Title:

Department:

Professional Mailing Address:

Phone Numbers:

Office:

Cell:

Pager:

Professional Email Address**:**

*NOTE TO PRINCIPAL INVESTIGATORS:* ***Please attach CV (no more than 5 pages please)***

**OTHER TEAM MEMBERS BIOGRAPHICAL INFORMATION:**

Name/Title:

Department:

**PROJECT DESCRIPTION**

**Project Overview** (one page maximum)

**Describe how your project promotes patient safety improvements and the potential to reduce claims or litigation.** (one page maximum)

**Describe how COM faculty, UFP clinic staff, UF Health Shands staff or other UF Health Science center staff and faculty will work together to accomplish stated project goals** (one page maximum)

**Describe the project methodology and timeline** (five page maximum)

**Describe how you will measure project success** (one page maximum)

**Describe your plans for completing a CME program and presenting, publishing or disseminating the project results locally and beyond** (one-half page maximum)

**References** (one-half page maximum)

***NOTE: After your project is completed, you need to complete a UF CME application for the educational program that will result from the project. Examples of an educational program can include a grand rounds activity, a presentation, or materials that can be placed on the internet for others to access at their convenience.***

**BUDGET REQUEST**

**Total Amount Requested:**

**Anticipated Project Duration:**

**Budget Category Amount Requested**

***Personnel***

Consultants

OPS/Temporary Staff

Other

Total

***Operating Expenses***

Office supplies

Computer supplies

Travel (in-state)

Travel (out-of-state)

Office equipment

Printing

Postage/mailing

Food

Miscellaneous

Total

**Total Expenses**

***NOTE: Award monies may not be used to support new FTE lines, existing FTE salaries or ongoing expense commitments that extend beyond the award period. Proposed travel budget expenses to conferences should only be budgeted for purposes of poster or lecture presentations on completed project results with total amount restricted to $5,000 or less.***

**BUDGET JUSTIFICATION:**

*Describe each major budget category according to its direct relationship to achieving stated project goals.*

**Signatures:**

*Please place a date signed by each signature*

Principal Investigator \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Co-Investigator(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Acknowledged:**

Department Chair

 Or

Hospital Leader \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Department Administrator \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_