**BOSTON UNIVERSITY SCHOOL OF MEDICINE**
**RADIOLOGY DEPARTMENT**
**RADIOLOGY RESEARCH**
**(CREDIT/NON-CREDIT)**
**Medical Student**

_____ _____
**Student Name** **Date**

_____
**E-Mail**

**Principal Investigator and Resident Name:**
_____

**Principal Investigator and Resident Signature:**_____

**Radiology Section (i.e. Body, Neuro, etc.):**
_____

**IRB No.** _____

_____ _____
**Student's Signature** **Signature of Medical Student Coordinator**

**Please Note:**
All radiology research project forms for credit and non-credit must be signed by the radiology medical student coordinator prior to beginning your research project.

For the BUSM Course 900.1 Radiology Research Elective for Credit, please contact the Medical Student Coordinator to complete the 'Research Elective Approval Form' with your proposal, obtaining supervising attending signature and medical student coordinator signatures prior to submitting to the registrar's office.

Return completed form to: Mariama.Bah@bmc.org

Mariama Bah
Radiology – Medical Student Coordinator
Boston University School of Medicine
Radiology Department
820 Harrison Avenue, FGH Bldg, 3rd Floor
Boston, MA 02118