



University of Puerto Rico School of Dental Medicine

AUTHORIZATION FOR RESEARCH PROJECTS

Date: Month/Day/Year	Name of principal investigator (PI): (Must be a faculty member)
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Name of applicant: <input type="checkbox"/> Student <input type="checkbox"/> Faculty <input type="checkbox"/> Other: _____	PI'S SIGNATURE _____	
	Email: _____	Phone number: _____

Project title:

Objectives

Abstract

Significance

<input type="checkbox"/> new IRB application	<input type="checkbox"/> IRB renewal . IRB approval #: _____ Expiration date: / / Month/Day/Year
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AUTHORIZED SIGNATURES

The School of Dental Medicine approves and endorses the project and is committed to collaborate to allow the accomplishment of the objectives. This support is subject to the continuous compliance of the institution's regulations and human rights at all times.

Privileges and access to:

students and/or their information faculty and/or their information patients and/or their information

use of facilities other (please specify):

_____ Augusto Elías-Boneta, DMD, MSD, DHC Assistant Dean of Research	Elaine M. Pagán, DMD, MSD Interim Associate Dean
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