MATERIAL TRANSFER AGREEMENT (MTA)/

DATA USE AGREEMENT (DUA)   
INTAKE FORM

Date:

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| A. INVESTIGATOR INFORMATION | |  | |
| CHLA Scientist’s Name | | | |
| CHLA Scientist’s Phone | | CHLA Scientist’s Email | |
| CHLA’s Contact, if different from CHLA Scientist (e.g., coordinator): | | | |
| Contact Name: | | | Contact Email: |
| External Organization’s Name | | | |
| External Organization’s contact information: | Name: | | Email: |
| External PI’s Name | | | |
| B. ABOUT THE MATERIAL/DATA SET BEING REQUESTED | | | |
| Are materials (physical samples) being transferred?  Yes  No  Who is providing the material?  CHLA  External Organization  Both  Are the materials human samples or data derived from humans?  Yes (IRB approval no.      )  No  Description of material (if “Both” was selected above, provide separate descriptions for CHLA’s and the other organization’s materials): | | | |
| Is a patient data set being transferred?  Yes  No  Who is providing the data set?  CHLA  External Organization  Both  Describe the data set (e.g.: EEG data from patients with Alzheimer’s, Los Angeles traffic pattern data, etc. Additionally, if “Both” was selected above, provide separate descriptions for CHLA’s and the other organization’s data sets):  IRB status for the data:  Approved (IRB no.      )  Exempt (IRB no.      )  Pending  DESCRIBE THE NATURE OF THE DATA SET:   * Protected Health Information (PHI) includes at least one direct identifier such as:   + names, street addresses, telephone numbers, fax numbers, e-mail addresses, Social Security numbers, medical record numbers, health plan beneficiary numbers, account numbers, certificate license numbers, vehicle identifiers and serial numbers (including license plates), device identifiers and serial numbers, URLs, IP address numbers, biometric identifiers [including finger and voice prints, full face photos [or comparable images]) * Limited Data Set may include:   + dates such as admission, discharge, service, DOB, DOD; city, state, five digit or more zip code; and age in years, months or days or hours)   + none of the identifiers listed above for PHI * Completely De-Identified Data Set:   + includes no personal identifiers as listed above for both PHI and Limited Data Set * If PHI, please attach a copy of your IRB approval letter covering use of the inbound PHI. * Coded data is not completely de-identified if it includes elements from a Limited Data Set.   Protected Health Information  Limited Data Set  Completely de-identified data | | | |
| After the recipient analyzes the material/data, do they need to return a copy of the results/analysis to the provider?  Yes  No | | | |
| Title of Study (at Receiving Institution): | | | |
| Will the recipient of material/data publish results independently, or should publications be a joint effort by CHLA and the other organization?  Independent publications  Joint publications | | | |
| Could the research lead to a patentable invention?  Yes  No  Possibly | | | |
| C. ABOUT THE DATA (ANSWER IF PROVIDING MATERIAL/DATA; if not, skip to D) | | | |
| Was the material/data originally given to CHLA by, or developed in conjunction with, a third party (not the External Organization named above)?  Yes  No  If yes, please provide their name, institution, and email address:  If yes, was there an MTA/DUA in place to govern the original transfer of material/data?  Yes (MediTract no.      )  No | | | |
| Did CHLA generate the material/data as a result of sponsored research (e.g., federal, foundation, or industry funding)?  Yes (Funding source/sponsor:      )  No | | | |
| Aside from the patient data set described above, will you provide any confidential (non-published) information to the recipient? Information created by CHLA in the conduct of business, such as employee data, financial data and proprietary research data is confidential information that belongs to CHLA.  Yes  No | | | |
| Does the PI require the recipient to acknowledge CHLA (particularly the PI) in any publications (should the recipient publish independently)?  Yes  No | | | |
| Does the PI want to be reimbursed by the recipient for the cost and/or shipping of the material/data?  Yes (Amount: $      )  No | | | |
| D. ABOUT THE DATA (ANSWER IF RECEIVING MATERIAL/DATA) | | | |
| Will you share the provider’s materials/data with any outside (non-CHLA) third parties?  Yes (Organization(s):      )  No | | | |
| SPECIFY CHLA’S FUNDING SOURCE(S) FOR THE PLANNED EXPERIMENTS AT CHLA USING THESE MATERIALS/DATA  Industry. Please provide Sponsor Name(s) and protocol number here:  Federal Grant(s). Federal agency and grant number:  Non-federal Grant(s). Grantor Name(s) and grant number:  Unrestricted Funds  Other. Please describe: | | | |
| Please identify any existing commitments made to third parties regarding this research project and the transfer of material/data which are not already disclosed above: | | | |
| Aside from the patient data set described above, will you need to receive any confidential information from the provider of the material/data? Yes  No | | | |
| For materials only: will you use the material in conjunction with other materials received from a third party? Yes  No | | | |
| E. COMPLIANCE | | | |

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| Is the material a live animal or will it be used in animals?  Yes (IACUC approval no.      )  No |
| Is the material a Human Embryonic Stem Cell or does the research involve using induced pluripotent stem cells?  Yes (SCRO approval no.      )  No |
| Are the materials hazardous or infectious?  Yes (Safety and/or biosafety approval no.      )  No |
| For PI: In the previous 12 months preceding the date of your signature below, have you, your spouse/domestic partner, or dependent child(ren): (1) received any payments from, including reimbursement for travel, (2) held stock, stock options, or other equity interest in (excluding stocks held through mutual funds), and/or (3) held a managerial position with an organization other than CHLA, CHLA Medical Group, or USC?  Yes  No  *if Yes, complete* [*COI Disclosure Form*](https://disclose.usc.edu/) |
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| F. SIGNATURES |

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| **Div/Dpt Head Name:**  **Div/Dpt Head Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Div/Dpt Admin Name:**  **Div/Dpt Admin Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **Principal Investigator/Program Director**  I certify that the statements made in the above are true, complete and accurate to the best of my knowledge. I agree to accept the obligation to comply with terms and conditions of any potential agreement, to accept responsibility for the scientific and technical conduct of this project, and for the timely provision of all required reports. I also agree to administer the project in accordance with the policies and procedures of CHLA. I will ensure that all project personnel complete the required training programs. Until new project staff members have been trained, I will ensure that their work is closely supervised for compliance with regulations and policies CHLA, and applicable law. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties.  **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Signature Date** |

**Steps after completing this intake form:**

1. Send completed form to Contracts and Clinical Research (CCR), [CHLAclinicalresearch@chla.usc.edu](mailto:CHLAclinicalresearch@chla.usc.edu).   
   If you received an MTA/DUA draft from the external organization named above, include it with your email.
2. CCR drafts the MTA/DUA (or reviews the provided MTA/DUA) and distributes to the other organization.  
   If the other organization requests any changes, CCR negotiates and finalizes the contract terms.  
   CCR coordinates signatures on the final agreement.
3. CCR notifies you of the signed agreement. At this time, you may begin the material/data transfer.   
   TSRI MediTract Support will also upload the agreement to MediTract and notify the study team of the MediTract number.