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Glenrose Rehabilitation Hospital - Research Affiliate Application Form  
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**Instructions:**   
Principal investigators who are not Alberta Health Services employees, but who require access to Glenrose Rehabilitation Hospital (GRH) resources (property, equipment, patients, staff or data) to carry out their research must apply to become a research affiliate of the GRH. Applicants must hold an academic affiliation. Complete and return this form along with a current CV to [grhresearch@ahs.ca](mailto:grhresearch@ahs.ca).

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| --- | --- | --- |
| **DATE OF APPLICATION:**  **NAME:**  *(name with degrees as you wish them to be shown)* | | |
| **ACADEMIC APPOINTMENT(S) AND GRH TITLE:** *(example: Associate Professor, Department of Pediatrics, University of Alberta*  *Clinical Head, Pediatric Rehabilitation, Glenrose Rehabilitation Hospital*  ***Research Affiliate, Glenrose Rehabilitation Hospital)*** | | |
| **PHOTO USAGE: (please check one)**  *YES, you may use this photo for the Glenrose website and in Glenrose research print materials.*  *YES, you may use this photo for the Glenrose website ONLY.*  *YES, you may use this photo for Glenrose Research print materials ONLY.*  *NO, I do not wish to supply any photos for either the Glenrose website or any Glenrose research print materials.*  *Please contact me to discuss the use of photos for Glenrose research.* | | |
| **CONTACT INFORMATION:**  *Phone:*  *Fax:*  *E-mail:*  *Personal Web Site Address (if applicable):*  *Mailing Address:* | | |
| **EDUCATION:**  *Institution* | *Degree* | *Year* |
| **RESEARCH INTERESTS:** | | |
| **LIST OF KEYWORDS:**  *(Keywords that you would expect someone who was searching for you and/or your research on the internet would find you under)* | | |
| **BIOSKETCH:**  *(research focus, current activities, future directions, successes – 15 lines maximum)* | | |
| **CLINICAL OR POLICY IMPLICATIONS OF RESEARCH:** | | |
| **INSPIRATION/VISION STATEMENT:**  *(2-3 lines maximum)* | | |
| **RECENT PUBLICATIONS:**  *(maximum of 5, in order of preference to be added to profile as there may be space limitations….try to reflect the breadth and depth of your research)* | | |
| **RESEARCH GROUP PROFILE:**  (*Are you part of a research group? If so, provide the name of the group, members and their affiliation (including all academic, clinical, community and industry partners. Focus on the research group, its current activities, future directions and successes to date).* | | |

*NOTE: Please attach a current photo of yourself in (.jpg file format) to your email when returning this form.   
  
Thank you!*

**Consent To Collect, Use, and Disclose Stories, Photos and/or Video and Sound Recordings**

**Important** - Complete this form when a photo, audio, video or written recording is needed for media, promotions, publications, education, presentations and other similar purposes.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Name of Individual being recorded | | | | | | |
| Address | City/Town | Prov | | Postal Code | | Phone Number |
| Name of Individual giving consent (Individual or Authorized Representative) Self | | | | Source of Representative’s Authority  (Attach a copy of the document which authorizes you) | | |
| Type of recording (check all that apply)   * Still/Digital Photographs Sound Recordings Video Recordings (with or without sound) * Interviews/Writing/Stories/Narratives Other, specify | | | | | | |
|  | | | | | | |
| Scope of Use or Disclosure Internal only Both internal and external to AHS | | | | | | |
| Purpose of collection and disclosure   * Media Release/Interviews AHS Publications Quality Improvement * Promotions AHS or Hospital Presentations/Displays Quality and Patient Safety Reporting AHS Education AHS Website * Other, specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_ | | | | | | |
| Name of person or group the recording, story or photo is being shared with (For example “The General Public”, “Research  Papers”, “AHS Website”)  I authorize Alberta Health Services (AHS) to record me and/or take my photo and use them in communications about AHS programs and services. I understand there are many ways of sharing communication, including printed and electronic methods. I understand that the recording or photo may be shared with a range of people and groups.  I authorize AHS to use my name, address and telephone number to contact me about this consent.  I understand why these recordings and/or photos are being taken and how they may be used. I know that there are risks and benefits to giving this consent. I know that I can stop this consent at any time by informing AHS in writing.  I understand that AHS cannot control information once it has been shared outside of AHS. I understand that if I ask AHS to stop using my recordings and/or photos it will only stop additional use of those recordings and/or photos after the date my request is received by AHS.  I agree to release and discharge AHS and those that AHS is responsible for at law from the responsibility and liability of the content and claims for the printed/electronic communication where my information was used. I confirm that this release and discharge shall be binding upon my heirs, executors, administrators and assigns. | | | | | | |
| Date consent is effective (yyyy-Mon-dd) | | | | | Expiry date (yyyy-Mon-dd)  None | |
| Signature of Individual/Authorized representative giving consent | | | | | Date (yyyy-Mon-dd) | |
| **Witness:** I watched the Individual giving consent sign the consent form (witness must be at least 18 years of age) | | | | | | |
| Name | | | Signature | | | Date (yyyy-Mon-dd) |

The information on this form, together with any record authorizing a representative to act on behalf on the individual, is being collected under section 22 (3) and 23 of the Health Information Act and/or section 33(c) of the Freedom of Information and Protection of Privacy Act for the purpose of recording consent to the disclosure of health information and/or personal information in the specified recording. Information collected on this form will be retained in the client file. For questions about the collection of your information please contact the Communications Advisor working with you or call 403-943-1210.  
18273(Rev2015-07)