**Investigator-Sponsored Research (ISR) Proposal or Research Grant Request:**

This form is intended to communicate an investigator-sponsored research proposal or grant request for investigator-sponsored research. If your research concept is of interest to Shockwave Medical, additional documentation including a protocol, informed consent, draft case report forms and budget will be requested for further evaluation.

**Instructions for completion:**

This form is to be completed by the Investigator requesting support for research. Please complete all the fields in this form and submit to Shockwave Medical Affairs. medicalaffairs@shockwavemedical.com

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| **Section A:** General Request Information |
| Request Date: xx/xx/xxx |
| **Section B:** Investigator/Institution Information |
| Investigator Name: Please complete | Investigator Email: Please complete |
| Investigator Title: Please complete | Investigator Phone: Please complete |
| Institution Name: Please complete | Street Address: Please complete |
| City/Suburb: Please complete | State/Province: Please complete |
| Zip/Postal Code: Please complete | Country: Please complete |
| CV attached: [ ]  |
| **Section C:** Support Requested (*Check all that apply, include details in text field)* |
| [ ]  Shockwave Medical Funding. Amount requested: Please complete (required)[ ]  Shockwave Medical Product or Supplies. Describe request: Please complete [ ]  Device training. Describe request: Please complete**Is funding being requested from other sources/organizations?** [ ]  No [ ]  YesIf yes, please specify support requested and/or received for this study: Please complete |
| **Section D:** Study Information *(All sections must be addressed to be considered for review.)* |
| Study Title/Topic: Please complete |
| Primary Objective: Please completeHypothesis: Please completeStudy rationale and its relevance to Shockwave Medical: Please complete |
| Describe the study design (e.g., single-arm, observational study). Please include a flow diagram to illustrate complex designs: Please complete |
| Required number of patients. If possible, provide details of power calculation (e.g., power, level of significance, effect size and standard deviation, supportive citations): Please complete |
| Describe the enrollment criteria: Please complete |
| Describe the treatment details (e.g., procedural steps, lesions to be treated): Please complete |
| List the study endpoints, associated measurement methods and analysis plan: Please complete |
| List the number of centers: Please complete |
| Estimate study duration: *(Time in months for start-up, enrollment, and follow-up.):* Please completeEstimate study start date: Please completeEstimate study end date: Please complete |
| Describe the evidence dissemination plan: (Target scientific congresses, journals, submission dates, etc.): Please complete |