

MEDICAL COLLEGE OF WISCONSIN
Division of Biostatistics
Consulting Service Application

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This form is used in matching the client's needs with the proper statistical expert in order to ensure the best possible services. **This form must be returned to the Division of Biostatistics before an appointment can be scheduled.**

Please Type or Print

Date: _____

Name: (Last/First) _____

Title: Faculty Staff Resident/Fellow
 Grad Student Medical Student Other _____

Campus Mailing Address (Department): _____

(Building) _____ (Room Number) _____

If non-campus address, include street, city and zip code: _____

Phone (Office): _____ Pager #: _____

Fax (Office): _____ E-Mail: _____

Title of Research Project: _____

Stage of Research: Design (no data yet) _____ Grant Preparation: _____ Data Collection: _____

Analysis (data collected): _____ Peer Review: _____

Do you have IRB Approval? _____ Institution and IRB Approval Number _____

If design is completed, was a statistician consulted for design? Yes _____ No _____

If yes, provide name of statistician: _____

Indicate important time deadlines: _____

Results likely will be published as: Journal Article _____ Abstract _____

Give brief description of scientific background for study.

List briefly, the specific aims of the study. What data is to be used to achieve these aims?

Give brief description of data you have collected:

Signature (students, major professor must sign as well) _____