|  |  |
| --- | --- |
| Internal Reference |  |

Patient Representative Network Request Form

Complete this form to request assistance from our Patient Representative Network (PRN).

How to use this form

1. Provide full details of your project and describe the opportunity you would like our PRN to assist with.
2. Ensure you are realistic in your timelines by:
	1. Allowing enough time for us to connect you with members from our PRN.
	2. Giving a reasonable timeframe for our PRN members to provide input.
3. Return your completed forms and relevant attachments to research@prostatecanceruk.org. We will aim to get back to you within three working days upon receiving your request.
4. Following completion of the work, we expect you to provide us with feedback on how it went. This will help us to continually improve this service.

# Details of contact

|  |
| --- |
| *Please provide details of the person who we should communicate with regarding this request.* |
| Name |  |
| Job role |  |
| Organisation |  |
| Email |  |
| Phone  |  |

# Project details

|  |  |
| --- | --- |
| Project title |  |
| PI name |  |
| Organisation |  |
| Full lay description  | *Can be supplied as an attachment* |

# Funding details

|  |
| --- |
| *Please include details of the research funding application your request relates to, whether that is pre-application or post-award.* |
| Funder |  |
| Award Type  |  |
| Award Value (or approx.) |  |
| Funding call deadline date *(if applicable)* | *Please include this if you are requesting PRN input pre-application.* |
| Award start date  | *If funding has not yet been awarded, please include your anticipated start date.* |
| Award end date/duration |  |
| Project/Grant Reference no. |  |

# Opportunity details

|  |
| --- |
| *Please outline what kind of patient input you are requesting and when it is needed.* |
| Type of involvement | *Examples: survey, advisory group, review application*  |
| Number of representatives required  |  |
| Who are you looking for?Any special criteria required? | *Examples: types of disease, treatment experiences* |
| Date(s) of activity |  |
| End date |  |
| Other dates to be aware of / commitment |  |
| Location  |  |
|  |
| What type of work will the representative be required to do *(please provide as much detail as possible)* |
|  |
| Would the representative be required to travel to take part in the opportunity (Y/N) |  |
| If yes, where is the representative required to travel  |  |
| Will the representative be remunerated for their involvement (Y/N) |  |
| Please expand on the reasons for your answer above |  |
|  |
|  |  |

# Other requirements

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| --- |
| If anything is not currently captured in the form above or you feel there is something important we should note, please complete the box below. |
|  |
| How did you find out about our PRN services? |  |