

# Biostatistics Consulting Services Agreement

TJU Division of Biostatistics,  
1015 Chestnut St, Suite M100, Philadelphia, PA 19107

Agreement number 2007-\_\_\_\_\_

Date \_\_\_\_\_

Responsible Statistician \_\_\_\_\_

Estimated cost (optional; detail on back, if provided) \_\_\_\_\_

## Client Information (print)

Name(s) \_\_\_\_\_

Department \_\_\_\_\_

Address \_\_\_\_\_

Telephone # \_\_\_\_\_ Fax # \_\_\_\_\_ Email \_\_\_\_\_

Project Description \_\_\_\_\_

Does this project include the analysis of clinical data? \_\_\_\_\_ **If yes, the project's PI must provide Biostatistics a copy of the IRB approval letter.**

### [TO BE COMPLETED BY CLIENT AND HIS/HER DEPARTMENT OR DIVISION ADMINISTRATOR]

*I agree to pay for biostatistical services for this project. I understand that the Division of Biostatistics will initiate an inter-departmental charge (IDC) to cover this bill (up to the maximum authorized).*

\_\_\_\_\_  
Client's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
18-Character Charge Code for IDC

\_\_\_\_\_  
Account Expiration Date

\_\_\_\_\_  
Maximum Expense Authorized

\_\_\_\_\_  
Administrative Approval Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Contact Person's Name (Print)

\_\_\_\_\_  
Contact's Email

\_\_\_\_\_  
Contact's Telephone #

**[TO BE COMPLETED BY THE RESPONSIBLE STATISTICIAN]**

*Estimated hours, if requested by client, to be completed at time of initial consultation.*

*Actual hours to be completed at time of billing.*

		<u>Estimated Hours</u>	<u>Actual Hours</u>
Data Preparation		_____	_____
Statistical Analysis		_____	_____
Reporting		_____	_____
Meetings		_____	_____
Total Hours	Faculty	_____	_____
	Consulting Unit	_____	_____
	Clerical	_____	_____
Hourly Rate	Faculty	\$ <u>127.00</u>	\$ _____
	Consulting Unit	\$ <u>55.00</u>	\$ _____
	Clerical	\$ <u>28.00</u>	\$ _____
<b>Total Bill</b>		\$ _____	\$ _____

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**Signature of responsible statistician**