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HELEN WILLS NEUROSCIENCE INSTITUTE
UNIVERSITY OF CALIFORNIA
BERKELEY, CALIFORNIA 94720-3190

Request for Scanner Training: 3 T MRI, Brain Imaging Center

Date: _____

Your Name: _____

Your Position: (e.g. RA, postdoc, grad student) _____

Lab Head or Principal Investigator Name: _____

Your Department or Institution: _____

Intended Grant / Funding Source:_____
(Training time is not charged for. Indicate here the grant/funds you will use once qualified.)

CPHS Protocol Number _____ Expiration Date _____

CPHS Protocol Title: _____

Name of person granted CPHS approval: _____

Authorized by Lab Head or Principal Investigator : _____

Successful completion of Safety Training: ❒ YES ❒ NO

Grad students only - completed PSY214: ❒ YES ❒ NO

Authorized by BIC Manager: _____

Authorized by BIC Director: _____

*You MUST submit a current, date-stamped copy of the **first page of the APPROVED CPHS** protocol with this form. Please keep a copy of this form for your records.*