**Formulary and Best Practices Review Committee Submission Form**

**Date:**

**Submitting Faculty/Staff:**

**Department/Program:**

**Product/Device:**

**Justification:**(Please give an evidence-based justification of the product/device)

**Proposed Faculty Training**:

**Cost:**(Explain the cost of the new product/device)

**APPROVALS:**

**Originator Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_**

**IT Approval (if applicable):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_**

**Radiology Approval (if applicable):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_**

**Institutional Advancement (if applicable):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_**

**Department Chairman Approval: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_**

**Associate Dean of Clinical Affairs Approval: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_**

**Formulary and Best Practices Review Committee: (Stamp) Date:\_\_\_\_\_\_\_\_\_\_\_\_**