Ahmanson-Lovelace Brain Mapping Center
Equipment Approval Form

Date:	
LAB CONTACTS	
Primary:	**Job Title:**
Phone:	**Email:**
Secondary:	**Job Title:**
Phone:	**Email:**
AREA OF USE	
☐ 3T MRI ☐ 7T MRI ☐ PET ☐ NML ☐ PREP ROOM	
PURPOSE OF EQUIPMENT	
EQUIPMENT INFORMATION	
Equipment Name:	
Make/Model:	**Serial Number:**
Installation Required ☐ YES ☐ NO	**Amount of Installation Time:**

1. Will the equipment or accessory components be used in the MRI scanner room? ☐ YES ☐ NO
2. If yes, is it ☐ 3T or ☐ 7T MRI safe per the manufacturer? ☐ YES ☐ NO
   a. If no, has it been used in a ☐ 3T or ☐ 7T MRI study without incident? ☐ YES ☐ NO
   b. Documentation provided to BMC? ☐ YES ☐ NO
3. Are other researchers allowed to use this equipment? ☐ YES ☐ NO
4. Will the equipment be stored at the Brain Mapping Center? ☐ YES ☐ NO
   a. If yes, initial here to acknowledge that BMC is not responsible for this equipment. ___________

PRINCIPAL INVESTIGATOR	
Name:	
Email:	**Phone:**
Signature	**Date**
<<< BMC APPROVAL USE ONLY >>>	
Hand-Held Magnet Test: ☐ NO ATTRACTION ☐ SOME ATTRACTION ☐ ATTRACTION ☐ N/A	
Tech Notes:	
Passed RF Test: ☐ YES ☐ NO ☐ N/A	**Passed Tech Testing:** ☐ YES ☐ NO
Tested by Tech:	**Approved by Dr. Woods:** ☐ YES ☐ NO
Installation Date:	**Approval Date:**