

ファイザー
Quality Improvement Grants
申請の手引き
(Full Proposal用)

Log in



First time user? [Create your password](#)

Please Log In

Quality Improvement Application

* E-mail Address:

* Password:

Show password

登録頂いたメールアドレス、Password
を入力してください。

全ての入力が完了しましたら
"LOG IN"をクリックしてください。

LOG IN

[Forgot your password?](#)

Please note that you must have cookies and JavaScript enabled on your browser in order to successfully log in.

[Technical Questions](#)

[1] Welcome Page

EDIT PROFILE

LOGOUT

Welcome,

The organization you are currently associated with is **Pfizer japan**

メールアドレス (ID) やパスワードをはじめとした各種申請者情報の修正ができます。

Pfizer Quality Improvement

A quality improvement (QI) grant is a type of grant which consists of Pfizer funding to support independent projects for systematic and continuous actions that lead to measurable improvement in health care services and the health status of individuals and targeted patient groups and do not relate to a Pfizer asset. Quality improvement considers aspects of quality such as clinical competence, outcomes and process assessment, program evaluation, quality indicators, and quality assurance using methodologically rigorous protocols with an endpoint goal of readiness for application to practice.

Competitive Grant Program: Pfizer's competitive grant program involves a publicly posted Request for Proposal (RFP) that provides detail regarding the area of interest, sets timelines, and notes whether requests will be reviewed and approved internally or by an expert review panel (ERP). The RFP will also describe eligibility requirements and what information must be in the submission.

How To Apply



Questions & Technical Support



Grant Application & Process Overview

新しい申請の場合は、こちらをクリックしてください。

* 保存中の申請がある場合は、“Unsubmitted Requests”というセクションが表示され、“Continue”をクリックすると、申請手続きを再開できます。

Submit a Request

» START A NEW QUALITY IMPROVEMENT APPLICATION «

[2] Introduction

【注意】“半角英数字”で入力ください

Welcome Page

Introduction

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Fycc Information/Contracting Organization

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Introduction

★ indicates required field

This application is for seeking support from Pfizer for an independent quality improvement project.

If this grant request is approved, all payments will be made to the requesting organization.

Please note that all online application fields (and any uploaded documents associated with the initial application) must be completed in English.

Please provide the name and email address of the individual at your Organization that is authorized to sign the contract if this grant is approved.

Pfizer only requires one signature. If your Organization requires an additional signature please provide that name and email address in the optional fields below.

* Contract Agreement Terms If your grant is approved, your institution will be required to enter into a written grant agreement with Pfizer. Please [click here](#) to view the core terms of the agreement. Pfizer has recently revised its grant agreement templates based on feedback from both internal and external stakeholders. Pfizer has drafted the terms of these agreements to be balanced and reasonable and to further the goals of both parties. Negotiating grant agreements requires significant resources, so please ensure that your institution (including your legal department) is able and willing to abide by these terms before proceeding with submission of your application as they will need to be accepted in their entirety.

I agree to the Contract Agreement Terms

* Authorized Signatory Name Please ensure the person authorized to sign an agreement on behalf of the organization is listed here.

* Authorized Signatory Email

Additional Authorized Signatory Name (Optional)

Additional Authorized Signatory Email (Optional)

Fully Executed Contract Will be uploaded if your request is approved and a contract has been signed by all necessary parties.

How did you hear about us/this opportunity?

SAVE AND PROCEED

助成が決定した場合に、助成契約書 (Grant Agreement) にサインを頂く方の名前を入力してください。

メールアドレスを入力してください。

すべての入力が完了したら "SAVE AND PROCEED" をクリックしてください。

[Technical Questions](#)

[3] Contact Information

登録済の担当者名が表示されます



修正の必要がなければ、ボックスにチェックを入れて、
SAVE AND PROCEED をクリックしてください。

LOGOUT

Welcome Page Introduction **Contact Information** Organization Information Educational Partners Program Overview Demographics Budget Details Payee Information Compliance Commitment

Contact Information

* indicates required field

Please create or select (match) the main contact for this proposal. This contact should be yourself as you are the authorized submitter for your organization. Please indicate your title in the salutation box. (e.g. Prof, Dr, Mr., Mrs., etc.)

Match: Check the box to associate this individual with this application.

Name: [TEST TEST](#)
Telephone #: TEST
E-mail Address: TEST@PFIZER.COM

新たに連絡担当者の作成をされる際には、こちらをクリックし登録をお願いします。

SAVE AND PROCEED CREATE NEW

修正が必要な場合は、名前をクリックし、修正してください。

登録済の担当者名が表示されます

[Technical Questions](#)

すべての入力が完了しましたら
"SAVE AND PROCEED"をクリックしてください。

[4] Organization Information

Welcome Page

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Organization Information

* indicates required field

The Organization identified below will be the Organization that will be contracted (if Approved).

* Legal Entity Name Pfizer japan

VAT Registration Number If VAT registered, please add number here

Practice or Private Physician Office Could your organization be classified as a group practice or an individually owned private physician practice (i.e., an independent group of physicians not affiliated with a hospital, academic institution or professional society)?

Please note that Pfizer cannot provide grants to individuals, individually owned private physician practices or informal groups which are not legal entities.

* Organization Type Medical & Science Organization

* Country Japan

* Address 1 test-test

Address 2 (Optional)

* City test-city

Province

* Zip/Postal Code 123455

Website Address test

* Organization Mission Statement Please describe the mission or objectives of your organization.

(1996 character(s) remaining)

以下で入力する申請施設・団体がクリニック・診療所など個人所有の施設もしくは任意団体ではないことを確認の上、“No”を選択してください。

該当する団体タイプをプルダウンメニューから選択してください。

登録済情報から変更がある場合は、修正をお願いします。

すべての入力が完了しましたら“SAVE AND PROCEED”をクリックしてください。

団体の活動目的についての概略を記載してください。

SAVE AND PROCEED

[5] Partners/Collaborators/Joint Sponsors

Partners/Collaborators/Joint Sponsors

Be advised the Partners/Collaborators/Joint Sponsors are reviewed during the evaluation process. If the Partners/Collaborators/Joint Sponsors listed in your request are non-compliant with Pfizer policies and procedures from past approved grants it may impact the decision on your current submission. IMPORTANT: You must list all the Partners/Collaborators/Joint Sponsors involved in the initiative for which you are seeking support from Pfizer.

* Are there any Partners/Collaborators/Joint Sponsors assisting with the planning or implementation of this project?

How many Partners/Collaborators/Joint Sponsors are involved?

SAVE AND PROCEED

[Technical Questions](#)

申請予定のプロジェクトを他の団体と共同で実施する場合には、プルダウンメニューから“Yes”を選択してください。そうでない場合は、“No”を選択してください。

Yes を選択された場合、共同で実施する団体数をプルダウンメニューから選択してください。

「Yes」を選択された場合

Partners/Collaborators/Joint Sponsors

* indicates required field

Be advised the Partners/Collaborators/Joint Sponsors are reviewed during the evaluation process. If the Partners/Collaborators/Joint Sponsors listed in your request are non-compliant with Pfizer policies and procedures from past approved grants it may impact the decision on your current submission. IMPORTANT: You must list all the Partners/Collaborators/Joint Sponsors involved in the initiative for which you are seeking support from Pfizer.

* Are there any Partners/Collaborators/Joint Sponsors assisting with the planning or implementation of this project?

How many Partners/Collaborators/Joint Sponsors are involved?

* 1st Organization Name

* Organization Tax ID Number Enter "N/A" if the Partner Organization does not have a Tax ID.

* Contact Full Name

* Organization Email Address

団体の名称を入力してください。

TAX ID欄には“NA”と入力ください。

団体の連絡担当者名とメールアドレスを入力してください。

すべての入力が完了しましたら“SAVE AND PROCEED”をクリックしてください。

SAVE AND PROCEED

[6] Overview

Overview

* Competitive Grant Program Name

* Primary Area of Interest Please select the primary area of interest for this project

* Has your institution submitted this project for consideration to Pfizer previously?

* Title

* Abstract Please include a concise but comprehensive summary of your application including:
1. Project Background and Rationale
2. Project Aim(s)
3. Project Objective(s)
4. Target Population
5. Project Design and Methods
6. Project Assessment/Evaluation
7. Project Outcomes: how this initiative will lead to measurable improvement in the quality of life and health status of individuals and targeted patient groups (language copied from grant description).

(3000 character maximum)

Project Lead/Principal Investigator Salutation Please indicate your title (e.g. Prof, Dr, Mr., Mrs., etc.)

* Project Lead/Principal Investigator First Name

Project Lead/Principal Investigator Middle Name

* Project Lead/Principal Investigator Last Name (?)

* Project Lead/Principal Investigator Email

Project Lead/Principal Investigator Phone Number

Project Lead/Principal Investigator Degree

公募要項を参照し、プルダウンメニューから選択してください。

該当する領域をプルダウンメニューから選択してください。

申請するプロジェクトを過去にファイザーに申請したことがあれば、Yes を選択してください。

申請するプロジェクトのタイトルを記載してください。

申請するプロジェクトの概要を英語で記載ください。

プロジェクトの責任者 (Lead) のお名前、メールアドレス等をご入力ください。

[6] Overview

Overview

* indicates required field

* Estimated Project Start Date (?) Please note that the start date must be at least 90 days before submission.

MM/DD/YYYY

* Estimated Project End Date (?)

MM/DD/YYYY

プロジェクトの開始日と終了日をカレンダーから選択ください。

* Goals and Objectives Briefly state the overall goal of the project. List the overall objectives you plan to meet with your project both in terms of learning and expected outcomes. Objectives should describe the target population as well as the outcomes you expect to achieve as a result of conducting the project.

(4000 character maximum)

プロジェクトの目的の概略を英語で記載してください。

* Assessment of Need for the Project Please include a quantitative baseline data summary, initial metrics (e.g., quality measures), or a project starting point (please cite data on gap analyses or relevant patient-level data that informs the stated objectives) in your target area.

(4000 character maximum)

プロジェクトの必要性について英語で記載してください。

* Target Audience Describe the primary audience(s) targeted for this project. Also indicate whether the project outcomes will benefit the target audience. Describe the overall population size as well as the geographic location of the target audience.

(4000 character maximum)

プロジェクトの対象者（受講者等）について概略を英語で記載してください。

* Project Design and Methods Describe the planned project and the way it addresses the established need.

(4000 character maximum)

プロジェクトのデザイン・方法について概略を英語で記載してください。

* Innovation Explain what measures you have taken to assure that this project idea is original and does not duplicate other projects or materials already developed.

(4000 character maximum)

プロジェクトの画期性について概略を英語で記載してください。

[6] Overview

Welcome Page Introduction Contact Information Organization Information Partners/Collaborators/Joint Sponsors **Overview** Budget Details Payee Information/Contracting Org Compliance Commitment

Overview

(7000 character maximum)

* Evaluation and Outcomes Please describe how you plan to evaluate the effectiveness of your project. (4000 character maximum)

* Anticipated Project Timeline Describe the anticipated timeline for your project. (500 character maximum)

Additional Information If there is any additional information you feel Pfizer should be aware of regarding your project, please summarize here. (2000 character maximum)

* Organizational Details Describe the attributes of institutions/organizations/associations involved in the project and the leadership of the proposed project. Articulate the role of each proposed project. (4000 character maximum)

Full Proposal/Project Description If responding to a Request for Proposal (RFP), please refer to the information that should be captured in this upload. This information should be captured in this upload. This information should be captured in this upload. **UPLOAD FILE**

* Select the primary country for your proposed project

Select additional countries where your target audience reside(s).

- Afghanistan
- ALand Islands
- Albania
- Algeria
- American Samoa

プロジェクトの成果をどのように評価するのか概略を英語で記載してください。

プロジェクトのスケジュールの概略を英語で記載してください。

プロジェクトを実行する団体についての説明を英語で記載してください。

公募要項内 Appendixを参照し、以下事項について「日本語」で記載したファイル（word 等）を添付してください。

- * プロジェクトの背景・目的
- * プロジェクトのニーズ評価
- * プロジェクト対象者（受講者）
- * プロジェクトデザイン
- * プロジェクトの画期性
- * プロジェクトの評価・結果の測定
- * スケジュール
- * その他追加情報
- * 申請団体・プロジェクトメンバー
- * 予算詳細

Japanを選択してください。

[6] Overview

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Overview

* Project/activity related to pain or opioids Please indicate whether or not the project/activity for which you are seeking support from Pfizer is related to or includes discussions about pain or opioids.

NOTE: To be eligible for funding, project/activity related to opioids must include components: 1) Aimed at increasing awareness of the risks of opioid addiction, abuse, and misuse; and 2) Detecting and preventing abuse, misuse, and diversion of opioids.

* IRB/IEC approval required (?) Does the project require Institutional Review Board approval?

* Will any component of your project offer education credit?

SAVE AND PROCEED

申請するプロジェクトが「疼痛」もしくは「オピオイド」に関連する場合は“Yes”を選択し、Attestationを確認してください。

申請するプロジェクトの実施にあたりIRB（もしくはIEC）の承認を必要とするか否か、“Yes”“No”を選択ください。

“No”を選択してください。
（日本のプログラムは、原則 YES にはなりません）

すべての入力完了したら
“SAVE AND PROCEED”をクリックしてください。

[7] Demographics

Demographics

プロジェクトメンバーの人数を半角数字で入力してください

Estimated Size of Project Team

プロジェクトメンバーの職業を選択してください。複数選択する場合は、Ctrlを押しながら選択してください。

Project Team Healthcare Professionals (HCP) (?)
Dieticians
Nurse Practitioners
Nurses
Pharmacists
Physician Assistants

プロジェクトチームの専門性を選択してください。複数選択する場合は、Ctrlを押しながら選択してください。

Project Team Specialty (?)
N/A
Allergy and Immunology
Anesthesiology
Cardiology
Critical Care Medicine

プロジェクト対象者（受講者）の年齢層を選択してください。

Age Group Impacted Indicate the age group(s) of the populations studied

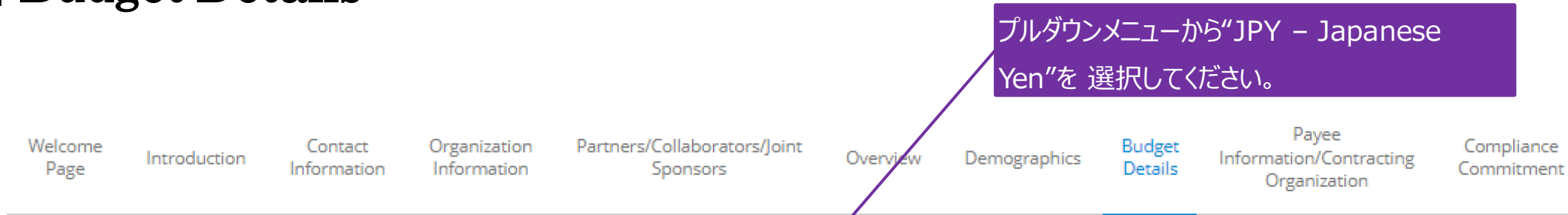
対象疾患領域における患者の人種を選択してください。複数選択する場合は、Ctrlを押しながら選択してください。

Patient Population Impacted Indicate the ethnicity of the population.
African
Asian
Caucasian
Hispanic
Open to All

SAVE AND PROCEED

すべての入力が完了しましたら
"SAVE AND PROCEED"をクリックしてください。

[8] Budget Details



プルダウンメニューから“JPY – Japanese Yen”を選択してください。

Budget Details

Please note all budget information should be entered in local currency. However, if you are responding to a Request for Proposal that document.

* Currency Code Local Currency Code for request amount (Must be completed first)

弊社からの助成金は PC・iPhone・カメラなどプロジェクト終了後に申請団体の資産となりうる高額な備品の購入に充てることができないことを確認してください。(レンタルは可)

* Infrastructure Expenses Independent medical grants must not be used to support infrastructure expenses (e.g. equipment, technology, bricks and mortar). Examples of equipment include, but are not limited to: Computers, iPhones, tablets, appliances, machinery, camera equipment, sensors etc. Equipment must be included in the project budget.
 I confirm my budget does not contain any requests for funds

請求書の費用 (IRB 等) がプロジェクト予算に含まれていることを確認してください

Invoices Pfizer does not directly pay invoices for independent medical grants. Please ensure costs for any study related invoices (i.e. IRB/EC fees) which are to be paid by institution, are included in the project budget.
 I Agree

* Items of Value You agree that, if approved, no portion of a Pfizer independent grant will be used for items of value for faculty, learners or participants. This includes but is not limited to honoraria, stipends or gift cards provided to HCPs to take anonymous surveys.
 I agree

弊社からの助成金は、講師や参加者に提供する“価値あるもの(教科書など)”に充てることができないことを確認してください。尚、この文章内に記載はございませんが、プロジェクト対象者(受講者)の個人費用(参加費・交通費・飲食費)や懇親会費にも充てることはできません。

重要

[7] Budget Details

Is your organization able to accept funds directly from Pfizer which is based in the United States? (?)

Direct Labor Costs Worksheet

Which role(s) are you requesting funds from Pfizer? (At least 1 role should be selected requested, please select one role and include \$0 for salary.)

***** Role *****	Total Project Salary	Hourly Rate	% effort over the year
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

+ ADD NEW ROW

弊社助成金はアメリカより海外送金されます。申請施設／団体がアメリカからの送金を受領できるかどうか、ご確認ください。受領不可の場合、お支払いすることができません。

重要

弊社助成金を充てたいと考えている役割にチェックを入れてください。各項目に関する詳細（単価・必要な期間）を要求する欄が表示されますので、それらの情報を入力してください。

Project Costs Worksheet

Please enter the associated project costs, amounts, and description tied to this request.

Project Costs	Cost	Description (Required if "Other Fees" is selected)
<input type="text"/>	<input type="text"/>	<input type="text"/>

+ ADD NEW ROW

弊社への助成申請額の内訳を各項目ごとに入力してください。各項目に該当しないものは、Other Fees に計上し、次ページに最下段の“Budget Narrative”にその詳細を記載してください。
注）消費税込で入力してください。弊社から別途消費税分を支払うことはできません。

重要

[8] Budget Details

Describe Other Fees

Institutional Overhead Percentage (?) Pfizer maintains a maximum allowed overhead rate of 28% for independent grant projects. Please [click here](#) for details. If overhead is not required, please enter "0" (zero) in this field.

Institutional Overhead Subtotal (?) Institutional Overhead Subtotal = (Direct Labor Costs Subtotal + Direct Study/Project Costs Subtotal) * Institutional Overhead Percentage

Total Amount Calculated (?)

* Requested Amount from Pfizer Enter the amount requested in your local currency. Enter numbers only; do not include currency symbols. This Total should match the Total Amount requested.

* Total Budget for Study/Project (?)

* Other Sources of Support? Will support (e.g. funding, drug, lab testing) by

* Budget Narrative (?)
(4000 character maximum)

弊社への助成依頼額を入力してください。

プロジェクトの総予算を入力してください。

弊社以外からの資金援助がありましたら "Yes" を選択し、どこからの支援なのか記載をしてください。

上記で、Other Fees に計上しているものがありましたら、ここに説明を記載してください。その他、プロジェクト予算について、詳細がわかるよう、ここに記載をしてください。

SAVE AND PROCEED

すべての入力完了しましたら "SAVE AND PROCEED" をクリックしてください。

重要

赤いアスタリスク (*) 以外は任意入力です。別途予算書（日本語可）を作成し、プロジェクト申請書と一緒に「Overview」の "Full Proposal/Project Description" の箇所にアップロードしてください。

注) 予算書には、消費税込の金額を入力してください。弊社から別途、消費税分の支払いをすることはできません。

[9] Payee Information/Contracting Organization

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Payee Information/Contracting Organization

Payments can be made to an AFFILIATED foundation (not-for-profit organization). Under no circumstances will Pfizer make payments to Sponsors; only to the requesting organization or an affiliated foundation.

Please provide the full company headquarter's name and address. This address should match the form W-8 or form W-9. Payments will not be sent to P.O. Boxes.

採択された場合の入金先/契約先が、申請団体と異なる場合は、“Yes”を選択し、必要情報を入力してください。

* Payment to Affiliated Foundation? If your request is approved and you would like the payment to be made to an affiliated Foundation (separate entity with a different tax ID) change this answer to 'Yes'.

* Payee Name1

* Payee Country

* Payee Address1 Checks will not be sent to P.O. boxes.

Payee Address2

* City

Province

Zip/Postal Code

SAVE AND PROCEED

すべての入力が完了しましたら
“SAVE AND PROCEED”をクリックしてください。

[10] Compliance Commitment

Compliance Commitment

* indicates required field

- * Compliance Certification Please read the following certification carefully. You must certify the following before you can submit your request to Pfizer for consideration. Please certify your agreement by clicking "I agree".
- You certify that you are an active employee of the requesting organization, with the responsibility and authorization to apply for financial support from Pfizer.
- You certify that you have no knowledge that Pfizer has had involvement in the creation or development of this project.
- You certify that, if approved, you will disclose the source of all support from Pfizer in all publications and presentations. When Pfizer support is "in-kind" the nature of the support must be disclosed to learners.
- You certify that, if approved, you will provide Interim Reports every six months throughout the lifecycle of the project, as well as a Final Report at the conclusion of your project. You also agree to provide monthly patient enrollment reports for clinical studies involving human subjects. If any of these required reports becomes overdue, Pfizer reserves the right to share your name with other representatives from your organization to assist in resolving the non-compliance. Further, you acknowledge non-compliance of required reports for previously approved grants may render your Institution as ineligible for new grants from Pfizer.
- You certify that, if approved, in the performance of all activities related to an independent medical grant, you will comply with all applicable Global Trade Control Laws. "Global Trade Control Laws" include, but are not limited to, U.S. Export Administration Regulations; the International Traffic in Arms Regulations; EU export controls on dual-use goods and technology; Financial Sanctions Laws and Restrictive Measures imposed within the framework of the CFSP - Treaty on European Union; and the economic sanctions rules and regulations administered by the U.S. Treasury Department's Office of Foreign Assets Control.
- You certify that, if approved, the grant has not been and will not be conditioned on (a) any pre-existing or future business relationship with Pfizer; or (b) any business or other relationship to be made, relating to Pfizer or its products (including coverage or formulary status decisions).
- Further you certify that you are authorized to submit an application and provide information in an application on behalf of the requesting organization and any partner organization(s), and you affirm that all responses and information provided in this application are truthful, accurate and complete. Your certification also represents that neither you nor your organization's directors, trustees, and/or anyone who will be involved in the project(s) that will be funded by this grant are on the OIG debarment list.
- Please note, if the request is approved your organization will be required to sign a contract which includes additional terms and conditions as they relate to the grant.**
- I agree to the Compliance Certification

ご同意頂けましたら、チェックをお願いします。

SAVE AND PROCEED

すべての入力が入力完了しましたら
"SAVE AND PROCEED"をクリックしてください。

すべての項目の入力が完了しましたら、今まで入力した内容をご確認頂けます。
内容に問題なければ、“SAVE AND PROCEED”をクリックしてください。

以上で申請は完了です。
ご不明な点がありましたらこちらまでご連絡ください。

Global Medical Grants & Partnerships
meg.japan@pfizer.com