Date Received: _____

Memorial Health University Medical Center
Institutional Review Board

SUBMISSION FOR FINAL REPORT OF ORIGINAL STUDY

Study Title:

MHUMC Study Number *(assigned by IRB):* **Initial approval date:**

This study involved: ☐ Clinical treatment ☐ Pre-existing data/tissue ☐ Questionnaire/survey

RESEARCH TEAM

Principal Investigator Information:
Name: Phone:
Address: Email:

Program Director:

Sub-investigator(s):

Study Coordinator:

SUMMARY OF ENROLLMENT

Total # accruals: → # Completed: # Withdrawn:

Reason for withdrawal(s):

SUMMARY OF STUDY RESULTS

_____ _____
Principal Investigator (signature) Date

_____ _____
Program Director (signature) Date

**** * * Section below for IRB administrative use only * * ****

☐ Approved by Expedited Review _____ _____ IRB Chair Date	CPA#: _____ IRB Agenda: _____