**APPLICATION FORM FOR PROTOCOL REVIEW – RESUBMISSION (Form 2.1B)**

**TO THE PRINCIPAL INVESTIGATOR:** *OBTAIN AN ELECTRONIC COPY OF THIS FORM AND ENCODE ALL INFORMATION REQUIRED IN THE SPACE PROVIDED. PRINT NAME, DATE AND SIGN THIS FORM BEFORE SUBMISSION. INDICATE WITH A (✓) CHECK MARK THE APPROPRIATE TICK BOX.*

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| --- | --- | --- | --- |
| **Date of Submission (MMM/DD/YYYY)** |  | **IRB Protocol Number** |  |
|  |
| **Sponsor** |  | **Sponsor’s Protocol Number** |  |
|  |
| **Principal Investigator** |  | **Co-investigator(s) (if any)** |  |
|  |
| **Telephone Number** | **Mobile Number** | **Fax Number** | **Email Address** |
|  |  |  |  |
|  |
| **Preferred Contact** | [ ] Telephone | [ ] Mobile | **Department** **(for Residents/Fellows)** |  |
| [ ] Fax | [ ] Email |
|  |
| **Conflict of Interest Declaration** **(Relationship with sponsor)** | Are you a regular employee of the sponsor? | [ ] Yes | [ ] No |
| Did you do consultancy or part time work for the sponsor? | [ ] Yes | [ ] No |
| In the past year, did you receive Php250, 000 or more from the sponsor? | [ ] Yes | [ ] No |
| Other ties with the sponsor |
| **Conflict of Interest Declaration** *For non-sponsored protocols*  |  |  |  |
|  |
| **Principal Investigator’s Signature** |  |
|  |
| **Protocol Title** |  |
|  |
| **Submitted documents in letter sized paper (please specify):** |

All requirements must be submitted online to the official IRB email: irbmmc.admin@makatimed.net.ph for screening.

After receiving an e-mail notification that your submission is “complete”, submit one (1) hard copy to the IRB Office located at the 7th Floor, Keyland Center (Makati Medical Center Tower 3), 143 Dela Rosa cor. Adelantado Streets, Legaspi Village, Makati City. You may contact the IRB Secretariat Staff through the following:

1. Telephone: 8888-8999 Loc. 3973, 3972 and 7166
2. Email: irbmmc.admin@makatimed.net.ph

**CANCELLATION FEE**

A cancellation fee of (Php15, 000.00) will be charged to the sponsor or proponent if the protocol is not presented on date of review without any valid reason.

**CLINICAL TRIAL AGREEMENT (CTA)**

If applicable, a copy of the CTA may be submitted for parallel review by the Legal Counsel of Makati Medical Center.

Submitted by:

 **Signature above Printed Name Date (MMM/DD/YYYY)**