**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** | |  | | |
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| **Sponsor** |  | **Sponsor’s Protocol Number** | |  | | |
|  | | | | | | |
| **Principal Investigator** |  | **Co-investigator(s) (if any)** | |  | | |
|  | | | | | | |
| **Telephone Number/Messaging App** | **Mobile Number** | **Email Address** | | | | |
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| **Department**  **(for Residents/Fellows/Consultants)** | Resident  Fellow  Consultant  Others (Please specify): | | | | | |
|  | **Clinical Departments**  Anesthesiology  Cardiology  Dermatology  Emergency Department  Internal Medicine  Neuro Sciences  Neuro Surgery  Neurology  Obstetrics & Gynecology  Ophthalmology  Orthopaedic  Otorhinolaryngology  Pediatrics  Psychiatry  Pulmonary Medicine  Rheumatology  Surgery Office | | **Nursing & Patient Care Services**  Nursing Education, Research & Development  Cancer Center  General Medicine  Oncology  **Pharmacy Services**  Clinical Pharmacy  **Professional Cluster Services 1**  Anatomic Pathology  Cellular Therapeutics Center  Center for Tropical & Travel Medicine  Nuclear Medicine  Pathology & Laboratory  Pulmonary Laboratory  **Professional Cluster Services 2**  Center for Osteoporosis & Bone Health  **Medical Education & Research Division**  Clinical Research Center  Others (Please specify): | | | |
|  | | | | | | |
| **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* |  | | | |  |  |
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| **Principal Investigator’s Signature** |  | | | | | |
|  | | | | | | |
| **Protocol Title** |  | | | | | |

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

You may contact the IRB Admin Staff through the following:

1. Telephone: 8888-8999 Loc. 7166, 3973, 3972, and 7178
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.

Submitted by:

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