**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/Messaging App** | **Mobile Number** | **Email Address** |
|  |  |  |
|  |
| **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*  |  |  |  |
|  |
| **Principal Investigator’s Signature** |  |
|  |
| **Protocol Title** |  |

All requirements must be submitted online to the official IRB email: 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)**