**APPLICATION FORM FOR PROTOCOL REVIEW – AMENDMENT (Form 2.1C)**

**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 AN (X) 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* | |  | | | | |  |  |
|  | | |  | | | | | |
| **Principal Investigator’s Signature** | |  | | | | | | |
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| **Protocol Title** | |  | | | | | | |
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| **Date of Initial Approval (MMM/DD/YYYY)** | |  | | | | | | |

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| **Submitted documents in letter sized paper (please specify):** |

**PROTOCOL REVIEW FEE**

Protocol Review Fee (P5, 600.00) for sponsored study protocols conducted by consultants and investigators not affiliated with Makati Medical Center.

(\*Please make your check payable to Makati Medical Center – This fee is non-refundable and non-transferable once review is initiated.

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 Secretariat Staff through the following:

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

Submitted by:

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