



**METHODIST**

The Nebraska Methodist Hospital  
8303 Dodge Street  
Omaha, Nebraska 68114  
(402) 354-4000

# Institutional Review Board Annual Continuing Review Form

This form is to provide at minimum an annual status of a previously approved Study.

**IRB Meeting Date** dd/mmm/yyyy

**Attachment**

**Completed By** (initial / date)

## IRB Office Only

**TITLE of Clinical Research Study\***

**Principal Investigator's Name / Credentials\***

**Methodist IRB ID#\***

**Date of Original Methodist IRB Approval\***

**Study Enrollment Status\***      Open      Closed      Other

**Total Subjects locally enrolled to date\***

**Total Subjects globally enrolled to date\***

**Submission to IRB Date\***

## Status Clarifications

Is there reason to believe the potential risks/benefits to Subjects are materially different than at the time of the most recent review?

If yes, provide details.

No      N/A      Yes

Has the IRB received all known Adverse Event reports required to be reported for this Study?

If no, provide details.

No      N/A      Yes

Are there any significant, new alternative treatments available that should be brought to the attention of the consented Subjects?

If yes, provide details.

No      N/A      Yes

Are there any modifications to this Study that have not yet been reviewed by the IRB?

If yes, provide details.

No      N/A      Yes

Have there been any changes to the Financial Disclosure Forms (FDFs) not yet been reviewed by the IRB?

If yes, provide details.

No      N/A      Yes



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### Documentation\*

List any documents submitted with this request

### Additional Information

### Investigator's Certification\*

I certify the provided information on this form is complete and accurate to the best of my knowledge. I will advise The Nebraska Methodist Institutional Review Board of any changes to the above completed fields when I become aware.

### Signature of Principal Investigator or designee\*/\*\*

### Printed Name of Principal Investigator or delegated staff\*

### Title of Principal Investigator or delegated staff\*

### Date (If not provided above)

\* required field

\*\* An electronic signature or typed name constitutes a binding electronic signature for this study.