LECOM HEALTH INSTITUTIONAL REVIEW BOARD
PROTOCOL COVER SHEET

Project title: ____________________________

Principal Investigator: ____________________________

Telephone: ___________ Email address: ____________________________

Co-Investigators: ____________________________

Submission date: ___________ Target start date: ____________________________

Expected Duration of Project: ____________________________

Anticipated number of subjects: ____________________________

CERTIFICATION STATEMENT

By making this application, I certify that I have read and understand the College’s policies and procedures governing research activities involving human subjects. I agree to comply with the letter and spirit of those policies. I acknowledge my obligation to:

1. Accept responsibility for the research described, including work by students under my direction.
2. Obtain written approval from the IRB of any changes from the originally approved protocol BEFORE implementing those changes.
3. Retain signed consent forms in a secure location separate from the data for at least three years after the completion of the research.
4. Immediately report any adverse effects of the study on the subjects to the LECOM Health IRB, irblecom@lecom.edu.

Principal Investigator Signature ____________________________ Date ____________________________
FOR INTERNAL USE ONLY

IRB #: ________________

Reviewers: ____________________________

Date Submitted to reviewers:

Date of initial review:

Date approved: