Institutional Review Board
Miscellaneous Report Form

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

	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*

Total Subjects enrolled to date*

Method of Review Requested*

- ☐ **Expedited** (The form content poses no more than minimal risk to Subjects.)
- ☐ **Full Board** (The form content poses more than minimal risk to Subjects.)

Submission to IRB Date*

Summary of Report*

Documentation*

List any documents submitted with this request

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.