



**METHODIST**

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

**IRB Office Only**

**Institutional Review Board  
Protocol Deviation Form**

This form is to request acknowledgment of a protocol deviation.

**IRB Meeting Date** dd/mm/yyyy

**Attachment Completed By** (initial / date)

**TITLE of Clinical Research Study\***

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

**Methodist IRB ID#\***

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

**Method of Review Requested\***

**Expedited** (The modification poses no more than minimal risk to Subjects.)

**Full Board** (The modification poses more than minimal risk to Subjects.)

**Submitted to IRB Date\***

**Summary of Deviation\***

Include likelihood of similar event to occur

**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.