Fee Collection Form

1. Title of Protocol

2. Contact Information

2.1 Principal Investigator (PI)

<table>
<thead>
<tr>
<th>Name/Phone Number</th>
<th>Email Address</th>
<th>Department</th>
<th>Location/ Address</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
<td></td>
<td>□ Student  □ Resident/Fellow □ Nurse □ Physician</td>
</tr>
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<td>□ Other:</td>
</tr>
</tbody>
</table>

3. Indicate the source of funding of your project

<table>
<thead>
<tr>
<th>Sponsor Name</th>
<th>Address</th>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Contact Name for Billing</th>
<th>Email address</th>
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<tbody>
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</tbody>
</table>

Revised 8/3/2018 KD
CHS IRB Form 100C
Title of Study:

4. The study requires:

   _____ Full IRB Review ($2,500)- Includes Contract and Budget Review
   _____ Expedited Review ($800 add to Full Review Cost)
   _____ Continuing Review ($500)
   _____ Contract and Budget Review ONLY (not IRB approval) ($1500)
   _____ Amendment Fee ($150)
   _____ Research is unfunded (student/resident/nurse/fellow)

Signature

This page is to be signed by the principal investigator (PI). If the principal investigator is a resident, nurse, or student, the supervisor must also sign in the box below.

Principal Investigator

   I certify that the information I provide in this application is correct and complete. I also pledge that I will not change any of the procedures, forms, or protocols used in this study without first seeking review and approval from the Catholic Health Institutional Review Board.

☐ Attestation of Principal Investigator

__________________________________  _________________________________
Name/Signature of PI                Date

__________________________________  _________________________________
Chairperson Signature               Date

__________________________________  _________________________________
Approval Date                      Expiration Date

Revised 8/3/2018 KD