Legal Services Department
Institutional Review Board
Phone: (716) 821-4477
Fax: (716) 821-4465

Fee Collection Form

1. Title of Protocol

2. Contact Information

2.1 Principal Investigator (PI)

Name/Phone Number

Email Address

Department

Location/ Address

Status

☐Student ☐Resident/Fellow ☐Nurse ☐Physician

☐Other:

3. Indicate the source of funding of your project

Sponsor Name

Address

Contact Name for Billing

Email address

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