

APPLICATION FOR AN EXTERNAL INSTITUTION TO SERVE AS IRB OF RECORD

Instructions for Use: To be completed when a UPR MCS investigator is submitting an initial request to rely on an External IRB. Please upload this document on the New Study application in the electronic system.	
STUDY TITLE	
UPR MSC PRINCIPAL INVESTIGATOR	
Name and Degree:	
Department:	
Email Address:	Telephone Number:
CONTACT PERSON FOR UPR MSC STUDY TEAM	
Name:	
Department:	
Email Address:	Telephone Number:
STUDY INFORMATION	
Is the study FDA-regulated? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Does the study qualify as a clinical trial? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is the study going to recruit/enroll any of the following? <input type="checkbox"/> Prisoners <input type="checkbox"/> Pregnant <input type="checkbox"/> Minors <input type="checkbox"/> Cognitively Impaired <input type="checkbox"/> None	
REASON TO REQUEST A RELIANCE AGREEMENT BEING	
Please select one of the following:	
<input type="checkbox"/> Sponsor Requirement	
<input type="checkbox"/> NIH-Funded (Single IRB Mandate)	
<input type="checkbox"/> Part of a Network or Consortium which encourages Single IRB use	
<input type="checkbox"/> Not Required, But for Efficiency	
<input type="checkbox"/> Other (Explain):	
FUNDING INFORMATION	
Is the study funded? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Is use of a Central IRB a requirement of funding? <input type="checkbox"/> Yes <input type="checkbox"/> No	
List Funding Source(s): <input type="checkbox"/> Does not apply	
<input type="checkbox"/> Federal Government-specify:	
<input type="checkbox"/> Other-specify:	
Primary Awardee: <input type="checkbox"/> Does not apply	
<input type="checkbox"/> UPR MSC	
<input type="checkbox"/> Institution being requested to act as IRB of record	
<input type="checkbox"/> Other-specify:	
INFORMATION OF THE INSTITUTION THAT SERVE AS IRB OF RECORD	
Name of the Institution you are requesting to act as IRB of record:	
Federal Wide Assurance (FWA) # of IRB you are requesting to rely on:	
Does this institution have AAHRPP accreditation? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Which institution is expected to provide IRB review? <input type="checkbox"/> Academic Institution <input type="checkbox"/> Independent/Commercial IRB	
<input type="checkbox"/> Research Institute/Hospital	
Provide the following information for the IRB representative at the institution you are requesting to act as IRB of record:	
Name:	
Email address:	
Telephone number:	

LEAD INVESTIGATOR:	
Name and Degree:	
Institution:	
<input type="checkbox"/> Institution is the same as the IRB of Record institution.	
Email Address:	
CONTACT PERSON FOR LEAD STUDY TEAM	
Name:	
Email Address:	
Telephone Number:	
SIGNATURE	
_____	_____
Signature of the UPR MSC Principal Investigator	Date

OPPHI Use Only	
OPPHI/IRB Determination	
UPR MSC IRB will cede IRB review to external institution	<input type="checkbox"/> Yes <input type="checkbox"/> No
OPPHI/IRB Risk Assessment	<input type="checkbox"/> Minimal risk <input type="checkbox"/> Greater than minimal risk
DETERMINATION TO CEDE REVIEW TO EXTERNAL IRB	
Name of OPPHI/IRB Providing Authorization:	
_____	_____
Signature of Person Providing Authorization	Date