Harris County Hospital District

RENEWAL APPLICATION

General Information: Use this form when submitting a renewal

PROTOCOL INFORMATION

Protocol Number:
Protocol Title:

INVESTIGATOR INFORMATION

Name:	**Credentials:**	
Position Title:	**Department:**	
Mailing Address:		
City:	**State:**	**Zip Code:**
Phone:	**Fax:**	**Pager:**
Email:		

STUDY COORDINATOR

Name:	**Title:**	
Mailing Address:		
City:	**State:**	**Zip code:**
Phone:	**Fax:**	**Pager:**
Email:		

RENEWAL INFORMATION

Is recruitment active? ☐ **Yes** ☐ **No**

-- If no, why should stay active?

Have changes been made since last approval? ☐ **Yes** ☐ **No**

-- If yes, Please submit the approval letter and approved changes.

Total Number of HCHD patients enrolled since last approval?

General Summary

Total Number of HCHD patients enrolled?

A Summary of any interim findings, amendments, and/or publications since last approval.

Any adverse events reported? ☐ **Yes** ☐ **No**

-- If yes, Please describe.

Signature: _____ **Date:** _____