CALIFORNIA RURAL INDIAN HEALTH BOARD, INC.

CRIHB Institutional Review Board
Request for Continuation of Research Approval

Date of Request: __ __ ____

Protocol Approval Number: _____ **Date of Prior Approval:** __ __ ____

This Request for Continuation of Research Approval form must be submitted 11 months after approval. The Institutional Review Board needs at least one month to review any changes to the Research. If one year has passed since the last approval date, the law requires that you stop data collection, analysis, and reporting activities until the request is approved.

INSTRUCTIONS

Complete all questions on this form. Write "N/A" if not applicable.

Sign and date the HIPAA Privacy Regulations Written Assurance Agreement.

Attach a copy of any Progress Report(s) sent to the funder(s) or other documents detailing changes mentioned in this cover page. Include any changes in documents and procedures for obtaining Informed Consent, survey instruments, or other instruments for Data Collection.

Submit this request with the required documentation via mail OR email to:

Mail: Jeffrey P. Braff, DrPH, CIP, MPS, CRIHB IRB Chair
CA Rural Indian Health Board
1020 Sundown Way
Roseville, CA 95661

Email: CRIHB.IRB@crihb.org

Identifying Information

1. Name and Title of Principal Investigator (PI): _____
2. Organization Represented by PI (Tribe, Tribal Health Program, College/University, Agency):

   _____
3. PI Address: _____

   Telephone Number: (____) _____ - _____

   Email Address: _____

PLEASE ADD ADDITIONAL PAGES AS REQUIRED

Research Protocol Information

4. Beginning and Ending Dates of the Project: From: __ __ ____ To: __ __ ____
5. Source(s) of funding for the research: _____
6. Brief description of research progress (include the number of participants enrolled, number of participants refusing to participate, number of participants who dropped out of the project, and the number of participants for whom data collection has been completed):

7. Brief description of any changes in the research objectives or research activities that affect individuals or communities included in the research:

8. Brief description of all adverse events, grievances, or complaints involving any participants or their data that have occurred, as well as any precautions that are being taken as a result:

9. Brief description of any changes in the potential risks of the research to the individual and communities involved in the research. Please include documentation of the changes:

Risks, Benefits, and Privacy Protection Information

10. Briefly describe any changes in the potential benefits to the individuals and communities involved in the research project:

11. Briefly describe any changes in the plan for protecting personal health information or the plan to destroy identifying information connected with personal health information:

HIPAA Privacy Regulations Written Assurance Agreement

By signing the HIPAA Privacy Regulations Written Assurance Agreement the PI acknowledges and assures that all identifying information connected with the research protocol participant's protected health information will not be re-used or disclosed to any other person or entity, except as required by the HIPAA Privacy Regulations, for authorized oversight of the research protocol, or for other research as permitted by the Privacy Regulations and authorized by the IRB.

PI Name: _____
(Print Name)

PI Signature: _____ Date: __ __ ____