	DR. JOSE N. RODRIGUEZ MEMORIAL HOSPITAL AND SANITARIUM PhilHealth Accredited ● ISO 9001:2015 Certified	**FORM 10: FINAL REPORT FORM** Form Code: **SF.MCC.IRB.012.Rev1**

1. GENERAL INFORMATION			
Title of Study			
Version number/ date of the IREB-approved protocol			
IREB Code:		Study Site	
Name of Researcher		Contact information	
		Tel. No:	
Co-researcher (If any)		Mobile No.:	
		Email:	
Institution of Researcher			
Address of Institution			
Ethical clearance effectivity period	From:	To:	
Final Report			

2. Duration of the study (months)	
3. Number of participants	
Required in the study	
Enrolled in the study	
Lost to follow up	
Withdrawn from the study	
Experienced SAEs/SUSARs	
Completed the study	

Number of required participants	
4. Amendments to the original protocol (To include dates of approval)	
5. If terminated early, the reason for termination	
6. Progress report submitted (date of approval)	
7. Informed consent form used (Version number and date)	
8. Study objectives and summary of results	

Name of Primary Investigator and signature

Date

Received by:

Name of IREB staff and Signature

Date

PLEASE DO NOT FILL THIS PORTION. FOR IREB USE ONLY

Comments of the Primary Reviewer:

Recommended Action	
o	Approve

Type of Review	
o	Expedited

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o	Request further information
o	Recommend further action
Other comments	

o	Exempted
o	Full Board

Name and signature of Primary Reviewer

Date

Final Decision	

Name and signature of IREB Chair

Date