



COOK COUNTY HEALTH

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Investigator Manualⁱ **(Version 1.1)**

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Scope

Cook County Health (CCH) is the main and historic public healthcare safety net for the County of Cook. While all research at any health/human service institution is to be reviewed and monitored, CCH serves a higher proportion of vulnerable populations of all types than most research conducting institutions; thus a higher expectation exists for assuring protection of patients from undue harm. A well-documented history of unfair and harmful research practice examples, especially with vulnerable populations exists in the US and globally, right along with numerous examples of population exclusion from beneficial research initiatives. In fact, among many vulnerable populations, distrust of research and medical providers in general is not uncommon, due to real atrocities and perceived notions of past practices. Current Federal Rules, CCH IRB (Institutional Review Board) review, and monitoring policies are designed to protect against repeating both kinds of unacceptable practices. The mission of the CCH IRB is to protect human participants involved in research conducted by or through CCH and to ensure research is conducted in accordance with ethical principles and all applicable laws and regulations.

Throughout this document “institution” refers to Cook County Health & Hospitals System dba Cook County Health. CCH includes but is not limited to *Central Campus (John H. Stroger, Jr. Hospital of Cook County, Ruth M. Rothstein CORE Center, Professional Building, and Harrison Square)*, Provident Hospital of Cook County, Correctional Health Services, Cook County Department of Public Health (CCDPH), Ambulatory & Community Health Network (ACHN), CountyCare, and Health Plan Operations.

What is the purpose of this manual?

This document, HRP-103 - INVESTIGATOR MANUAL, is designed to guide you through policies and procedures related to the conduct of Human Research that are specific to this institution. You can find the referenced HRPP Toolkit documents on the Research & Regulatory Affairs Website (<https://cookcountyhealth.org/education-research/research/office-of-research-regulatory-affairs-irb/>).

General information regarding Human Research protections and relevant federal regulations and guidance is incorporated into the required human protections training. For additional information see below: [“What training does my staff and I need in order to conduct Human Research?”](#)

What is Human Research?

HRP-101 - HUMAN RESEARCH PROTECTION PROGRAM PLAN, CCH Policy #RA.011.01, defines the activities that this institution considers to be “Human Research.” An algorithm for determining whether an activity is Human Research can be found in HRP-310 - WORKSHEET - Human Research Determination, located in the HRPP Toolkit section of the IRB Web site (<https://cookcountyhealth.org/education-research/research/office-of-research-regulatory-affairs-irb/>). Use this document for guidance as to whether an activity meets either the DHHS or FDA definition of Human Research, keeping in mind that the IRB makes the ultimate determination in questionable cases as to whether an activity constitutes Human Research subject to IRB oversight.

You are responsible not to conduct Human Research without prior IRB review and approval (or an institutional review and determination of exempt Human Research). If you have questions about whether an activity is Human Research, contact the IRB Office who will provide you with a determination. If you wish to have a written determination, submit a request into IRBManager.

What is the Human Research Protection Program?

The HRPP stands for the Human Research Protection Program. The CCH HRPP is a collaborative effort between all who develop, conduct, review, approve and facilitate Human Research. Research & Regulatory Affairs is the department within CCH responsible for the CCH HRPP. IRB administrators working in the department support and coordinate the work of the CCH IRB. They may also serve as IRB members if they meet the requirements for membership. In addition, administrators provide a valuable resource for researchers involved in human subjects research because of their familiarity with relevant regulations and knowledge of institutional policies. The HRPP program frequently works with the Clinical Research Office, Sponsored Programs, Corporate Compliance, Legal, and institutional leadership to ensure the highest level of protections for our research participants.

HRP-101 - HUMAN RESEARCH PROTECTION PROGRAM POLICY, CCH Policy #RA.011.01, describes this institution's overall plan to protect participants in Human Research.

- The mission of the Human Research Protection Program.
- The ethical principles that the institution follows governing the conduct of Human Research.
- The applicable laws that govern Human Research.
- When the institution becomes "engaged in Human Research" and when someone is acting as an agent of the institution conducting Human Research.
- The types of Human Research that may not be conducted.
- The roles and responsibilities of individuals within the institution.

What is the IRB?

Purpose. Institutional Review Boards, or IRBs, review research studies to ensure that they comply with applicable regulations, meet commonly accepted ethical standards, follow institutional policies, and adequately protect research participants. IRB reviews help to ensure that research participants are protected from research-related risks and treated ethically, a necessary prerequisite for maintaining the public's trust in the research enterprise and allowing science to advance for the common good.

Composition. Each IRB must be appropriately constituted for the volume and types of human research to be reviewed, in accordance with federal regulations.

- The Common Rule requires at least five members with varying backgrounds on the IRB, so that research is reviewed from a collection of different perspectives. At a minimum, members must include someone who provides the perspective of a scientist, someone who provides the perspective of a nonscientist, and someone who is not affiliated with the research institution. The CCH IRB recognizes the importance of and includes local community members as non-affiliated members. See HRP- 304 – WORKSHEET – IRB Composition.

- The IRB, as a group, must be sufficiently qualified through the education, experience, expertise, and diversity of its members to be able to review the research activities commonly conducted by the institution. The committee strives for a balance of men and women, multiple professional specialties, and the racial/ethnic diversity found in the communities served by CCH. The CCH IRB has at least one “prisoner-representative” member who is an advocate for detained persons. See HRP- 30 – WORKSHEET – Quorum and Expertise.
- Alternate members appointed by the EMS with the same considerations as so-called “Permanent” members and are encouraged to attend all meetings. The participation of alternate members is welcome in all discussion and promotes the continuity of the Board’s review. If the total number of members present exceed the number of regular or “permanent” members on the Board, the votes of the alternate members are not counted or recorded. All members (permanent and alternate) may provide expedited review for initial protocols and continuing review when such review is delegated by the Chair.
- When the IRB receives protocol applications that require expertise beyond that available on the Board, assistance is sought from qualified persons outside the Board membership. Outside experts serve in a consultant role only. See HRP-051 -SOP – Consultation.

Commitment. Board members are appointed for a 3-year renewable term as per the Executive Medical Staff (EMS) Bylaws of John H. Stroger, Jr. Hospital of Cook County. The IRB meets twice monthly, to review protocol applications. Members are expected to attend all scheduled meetings. See HRP- 082 – SOP – IRB Membership Addition and HRP- 083 – SOP – IRB Membership Removal.

Conflict of Interest. IRB members with conflicting interests related to a protocol under review may provide information to the IRB, but may not participate or be present for discussion of approval and vote. Board members are expected to identify the individual conflict of interest for the meeting record if appropriate. See HRP- 050 – SOP – Conflicting Interests of IRB Members.

Training. IRB members are required to complete the HRPP CITI modules including the module for IRB members, the HRPP Toolkit training for IRB members, and an orientation with the HRPP Director. Periodic training sessions are held for new and existing members. The HRPP Toolkit SOPs, checklists, and worksheets are provided to IRB members for IRB reviews and discussions.

What training does my staff and I need to conduct Human Research?

This section describes the training requirements imposed by the IRB. You may have additional training imposed by other federal, state, or institutional policies. Instructions for training can be accessed at <https://cookcountyhealth.org/wp-content/uploads/CITI-INSTRUCTIONS.pdf>.

- Investigators and staff conducting research must complete the Collaborative Institutional Training Initiative (CITI) human subjects online training program. Training is valid for a three-year period, after which time the training must be repeated. The CITI site can be accessed at <http://www.citiprogram.org/>.

- Investigators and staff conducting research must also complete the Cook County Health Human Participants in Research Training prior to receiving access to the IRB Manager system and beginning any research. Email CCHHSIRB@cookcountyhhs.org to schedule a training session.
- Investigators and staff conducting research must also view and attest to watching the recording of the IRB Toolkit & FCOI training available in the LMS at <https://learningmanager.adobe.com/app/learner?accountId=97436#/course/7966950>.

All members of the research team involved in the design, conduct, or reporting of the research must complete training. Members of the research team who have not completed human research protections training may not take part in aspects of the research that involve human subjects.

Who can be the Principal Investigator (PI)?

CCH Policy #: RA.004.01, Principal Investigator Eligibility, must be followed when determining who can serve as the PI. This person should be listed in the IRBManager application form and takes overall responsibility for the study and supervision of study personnel.

What financial interests do my staff and I need to disclose conduct Human Research?

Individuals involved in the design, conduct, or reporting of research, research consultation, teaching, professional practice, institutional committee memberships, and service on panels such as Institutional Review Boards or Data and Safety Monitoring Boards are considered to have an institution responsibility to disclose their financial interests per [CCH Policy CC.007.02](#), Financial Conflict of Interest in Research .

Key personnel will receive an email when an initial application is submitted asking them to click on the following link to provide their signature confirming that they do not have any financial interests to disclose per CCH Policy CC.007.02. If key personnel have a financial interest to disclose, they will need to complete the “Financial Interest Statement” from their IRBManager dashboard:

- On submission of an initial review.
- At least annually as part of continuing review.
- Within 30 days of discovering or acquiring (e.g., through purchase, marriage, or inheritance) a new financial interest.

Individuals with reimbursed or sponsored travel by an entity other than a federal, state, or local government agency, higher education institution or affiliated research institute, academic teaching hospital, or medical center are required to disclose the purpose of the trip, the identity of the sponsor or organizer, the destination, and the duration of the travel.

Individuals subject to this policy are required to complete financial conflicts of interest training initially, at least every four years, and immediately when:

- Joining the institution
- Financial conflicts policies are revised in a manner that changes investigator requirements

- Non-compliant with financial conflicts policies and procedures

Additional details can be found in HRP-055 - SOP - Financial Conflicts of Interests.

How do I submit new Human Research to the IRB?

To begin an Initial Application, complete the xForm for an Initial Study in IRBManager. In the Actions on the left side of the IRBManager Home page, click on “Click here to submit a new Submission for CCHHS IRB Approval.” Complete the form and be sure to attach any related study materials to the submission.

How do I submit a request to use a Humanitarian Use Device (HUD) for clinical use?

Cook County Health utilizes the IRB to review and approve the use of a HUD before it can be used at a facility for clinical care. You can refer to HRP-323 - WORKSHEET - Criteria for Approval HUD for additional information regarding the criteria that the IRB uses to review and approve HUD uses. The clinical use of a HUD is not considered Human Research but must still be submitted for review and approval by the IRB prior to clinical use (with the exception of emergency use). An informed consent form is not required by the IRB for HUD use.

Complete the xForm for an Initial Study in IRBManager. In the Actions on the left side of the IRBManager Home page, click on “Click here to submit a new Submission for CCHHS IRB Approval.” Complete the form and be sure to attach any related study materials to the submission.

How do I request to rely on an external IRB?

Refer to HRP-832 - WORKSHEET - Considerations for Ceding IRB Review. Submit a new submission for CCH IRB approval on form HRP-211 – Basic Study Information in IRBManager indicating your request to rely on an external IRB. Be sure to include:

- Draft Reliance/Authorization Agreement if you do not have one in place already. If requesting reliance on a single IRB for individual studies, it is preferred to cede through SMART IRB and use the Template Letter: Acknowledgement of Site Agreement to Cede IRB Review and Reviewing IRB to Provide Oversight. A prefilled template is available on our website.
- External IRB study approval letter and site approval (if available).
- HRP-508 Template Site Supplement to Sponsor Protocol in addition to the Sponsor Protocol.
- Laboratory and/or Pharmacy Form if applicable.
- Informed Consent Document & HIPAA Authorization meeting local requirements if applicable.
- Informed Consent
 - First page must be on Cook County Health letterhead

- Local contact information including: local site PI name and contact information, local CCH IRB contact information, and the research team Institutional participant injury language
- Local compensation language for taxes and reporting
- Disclosure of COI language in the informed consent if required by management plan
- HIPAA Authorization
 - May use CCH HIPAA Authorization for Research template or may use other language if meets the requirements in HRPP-330 – WORKSHEET – HIPAA Authorization.
 - May use a standalone HIPAA authorization or combined with the informed consent document.

The IRB staff will pre-review your submission for accuracy and completeness. If changes or clarifications are required, the IRB office will return the application along with the reasons for return. Once corrected, resubmit your application. If the external IRB and submission meet institutional requirements, the IRB office will work to establish an institutional profile and communication plan with the external IRB and study team. The application will also be sent for administrative review by an IRB member to ensure local requirements are met as well as any other ancillary reviews that are applicable. If any changes or clarifications are required, the IRB office will return the application along with the reasons for return. Once corrected, resubmit your application.

When your study has been administratively approved, you will receive a letter indicating your request to rely on the external IRB has been approved. If you have not already submitted the external IRB's site approval, you must do so when it is available. Your reliance/authorization agreement will be routed for signature.

How do I request that this IRB serve as the IRB of record (sIRB) for my collaborative or multi-site research study?

The CCH IRB will not serve as the sIRB of record. If your study requires the use of a sIRB, please call our office to review your options. Make sure to budget for an external sIRB if needed.

How do I write an Investigator Protocol?

Use HRP-503 - TEMPLATE PROTOCOL as a starting point for drafting a new biomedical Investigator Protocol, and reference the instructions in italic text for the information the IRB looks for when reviewing research. Use HRP-503a - TEMPLATE SBS PROTOCOL for social and behavioral studies. Here are some key points to remember when developing an Investigator Protocol:

- The italicized bullet points in HRP-503 - TEMPLATE PROTOCOL serve as guidance to investigators when developing an Investigator Protocol for submission to the IRB. All italicized comments are meant to be deleted prior to submission.

- For any items described in the sponsor’s protocol or other documents submitted with the application, investigators may simply reference the page numbers of these documents within the Investigator Protocol rather than repeat information.
- When writing an Investigator Protocol, always keep an electronic copy. You will need to modify this copy when making changes to the Investigator Protocol.
- If you believe your activity may not be Human Research, contact the IRB Office prior to developing your Investigator Protocol.
- Note that, depending on the nature of your research, certain sections of the template may not be applicable to your Investigator Protocol. Indicate this as appropriate.
- You may not involve any individuals who are members of the following populations as subjects in your research unless you indicate this in your inclusion criteria as the inclusion of subjects in these populations has regulatory implications.
 - Adults unable to provide legally effective consent
 - Individuals who are not yet adults (infants, children, teenagers)
 - Pregnant women
 - Prisoners
- If you are conducting community-based participatory research, you may contact the IRB Office for information about:
 - Research studies using a community-based participatory research design
 - Use of community advisory boards
 - Use of participant advocates
 - Partnerships with community-based institutions or organizations

How do I create a consent document?

Use HRP-502 - TEMPLATE CONSENT DOCUMENT to create a consent document.

Note that all long form consent documents and all summaries for short form consent documents must contain all of the required and all additional appropriate elements of informed consent disclosure. Review the “Long Form of Consent Documentation” section in HRP-314 - WORKSHEET - Criteria for Approval, to ensure that these elements are addressed. When using the short form of consent documentation, the appropriate signature block from HRP-502 - TEMPLATE CONSENT DOCUMENT should be used on the short form.

If your research study meets the requirements for an exemption and there are interactions with subjects, you may use an abbreviated process for obtaining consent. Consent can be verbal, but you must provide the following information to participants through an information sheet or written script:

- The subject is being asked to participate in a research study;
- A description of the procedure(s) the participant will be asked to complete;
- Participation is voluntary; and

- The investigator's name and contact information.

We recommend that you date the revisions of your consent documents to ensure that you use the most recent version approved by the IRB. If you do not date the versions, the IRB office will use the IRB approval date as your version date.

Do I need to obtain informed consent in order to screen, recruit, or determine the eligibility of prospective subjects?

The IRB may approve a research proposal in which an investigator will obtain information or biospecimens for the purpose of screening, recruiting, or determining the eligibility of prospective subjects without the informed consent of the prospective subject or the subject's legally authorized representative, if either of the following conditions are met:

- (1) The investigator will obtain information through oral or written communication with the prospective subject or legally authorized representative, OR
- (2) The investigator will obtain identifiable private information or identifiable biospecimens by accessing records or stored identifiable biospecimens.

The research protocol should include information about how potential subjects will be identified and recruited in order for the IRB to be able to determine whether informed consent for these activities is required.

Contact the IRB Office with additional questions or for further guidance regarding the requirement to obtain HIPAA authorization or a waiver to obtain HIPAA authorization for recruitment purposes. Please see HRP-315- WORKSHEET – Advertisements and Recruitment.

How do I create a HIPAA authorization?

Cook County Health has a HIPAA Authorization for Research template available on the IRB Web Site under Templates & Forms at <https://cookcountyhealth.org/education-research/research/office-of-research-regulatory-affairs-irb/>. There is also a Spanish translated template available. Make sure you fill out the form specific to your study and submit along with your application in IRBManager. You have the option of imbedding the CCH HIPAA language into your consent form. If you have an existing consent form with HIPAA language already imbedded, ensure it meets the requirements in HRP-330- WORKSHEET-HIPAA Authorization for approval, and submit for approval.

What are the different regulatory classifications that research activities may fall under?

Submitted activities may fall under one of the following four regulatory classifications:

- Not "Human Research": Activities must meet the institutional definition of "Human Research" to fall under IRB oversight. Activities that do not meet this definition are not subject to IRB oversight or review. Review the IRB Office's HRP-310 - WORKSHEET - Human Research Determination for reference. Case reports and QA/QI projects may also fit into this category or may be human research which does require submission to

the IRB. If you are looking to recruit CCH patients for outside studies, this does need CCH IRB review. Please see HRP-315- WORKSHEET – Advertisements and Recruitment.

Contact the IRB Office in cases where it is unclear whether an activity is Human Research. If you need a written determination that the activity is not human research, please submit your project for a determination in IRBManager.

- Exempt: Certain categories of Human Research may be exempt from regulation but require IRB review. It is the responsibility of the institution, not the investigator, to determine whether Human Research is exempt from IRB review. Review the IRB Office's HRP-312 - WORKSHEET - Exemption Determination for reference on the categories of research that may be exempt.
- Review Using the Expedited Procedure: Certain categories of non-exempt Human Research may qualify for review using the expedited procedure, meaning that the project may be approved by a single designated IRB reviewer, rather than the convened board. Review the IRB Administration's HRP-313 - WORKSHEET - Expedited Review for reference on the categories of research that may be reviewed using the expedited procedure.
- Review by the Convened IRB: Non-Exempt Human Research that does not qualify for review using the expedited procedure must be reviewed by the convened IRB.

What are the decisions the IRB can make when reviewing proposed research?

The IRB may approve research, require modifications to the research to secure approval, table research, defer research or disapprove research:

- Approval: Made when all criteria for approval are met. See "[How does the IRB decide whether to approve Human Research?](#)" below.
- Contingent Approval: Made when IRB members require specific modifications to the research before approval can be finalized.
- Tabled: Made when the IRB cannot approve the research at a meeting for reasons unrelated to the research, such as loss of quorum. When taking this action, the IRB automatically schedules the research for review at the next meeting.
- Deferred: Made when the IRB determines that the board is unable to approve research and the IRB suggests modifications that might make the research approvable. When making this motion, the IRB describes its reasons for this decision, describes modifications that might make the research approvable, and gives the investigator an opportunity to respond to the IRB in person or in writing.
- Disapproval: Made when the IRB determines that it is unable to approve research and the IRB cannot describe modifications that might make the research approvable. When making this motion, the IRB describes its reasons for this decision and gives the investigator an opportunity to respond to the IRB in person or in writing.

How does the IRB decide whether to approve Human Research?

The criteria for IRB approval can be found in HRP-312 - WORKSHEET - Exemption Determination for exempt Human Research and HRP-314 - WORKSHEET - Criteria for Approval for non-exempt Human Research. The latter worksheet references other checklists that might be relevant. All checklists and worksheets can be found on the IRB Web site.

These checklists are used for initial review, continuing review, and review of modifications to previously approved Human Research.

You are encouraged to use the checklists to write your Investigator Protocol in a way that addresses the criteria for approval.

What will happen after IRB review?

The IRB will provide you with a written decision indicating that the IRB has approved the Human Research, requires modifications to secure approval, or has disapproved the Human Research.

- If the IRB has approved the Human Research: The Human Research may commence once all other institutional approvals have been met. IRB approval is usually good for a limited period of time which is noted in the approval letter.
- If the IRB has contingently approved the Human Research and requires modifications to secure approval and you accept the modifications: Make the requested modifications and submit them to the IRB. Submit a point-by-point response to the IRB's letter and revise your application, protocol, consent, and any other relevant documents in IRBManager. If all requested modifications are made, the IRB will issue a final approval. Research cannot commence until this final approval is received. If you do not accept the modifications, write up your response and submit it to the IRB.
- If the IRB defers the Human Research: The IRB will provide a statement of the reasons for deferral and suggestions to make the study approvable and give you an opportunity to respond in writing. Submit a point-by-point response to the IRB's letter and revise your application, protocol, consent, and any other relevant documents in IRBManager. In most cases if the IRB's reasons for the deferral are addressed in a modification, the Human Research can be approved.
- If the IRB disapproves the Human Research: The IRB will provide a statement of the reasons for disapproval and give you an opportunity to respond in writing.

In all cases, you have the right to address your concerns to the IRB directly at an IRB meeting.

What are my obligations after IRB approval?

- 1) Do not start Human Research activities until you have the final IRB approval letter.
- 2) IRB approval does not constitute institutional approval. Do not start Human Research activities until you have obtained all other required institutional approvals, including approvals of departments or divisions that require approval prior to commencing research that involves their resources. The protocol cannot be opened until all required institutional agreements with third parties such as Clinical Trial Agreements, Data Use Agreements and

Material Transfer Agreements are executed (as applicable) and reviewed for harmonization with the final protocol and approved informed consent documentation by the Clinical Research Office (CRO). Please check with the CRO to ensure that you can initiate study activities for any protocol that involves an external sponsor, funder, grantor, or collaborator.

- 3) Ensure that there are adequate resources to carry out the research safely. This includes, but is not limited to, sufficient investigator time, appropriately qualified research team members, equipment, and space.
- 4) Ensure that Research Staff are qualified (e.g., including but not limited to appropriate training, education, expertise, credentials, protocol requirements and, when relevant, privileges) to perform procedures and duties assigned to them during the study.
- 5) Update the IRB office with any changes to the list of study personnel.
- 6) Personally conduct or supervise the Human Research. Recognize that the investigator is accountable for the failures of any study team member.
 - a) Conduct the Human Research in accordance with the relevant current protocol as approved by the IRB, and in accordance with applicable federal regulations and local laws.
 - b) When required by the IRB ensure that consent or permission is obtained in accordance with the relevant current protocol as approved by the IRB.
 - c) Do not modify the Human Research without prior IRB review and approval unless necessary to eliminate apparent immediate hazards to subjects.
 - d) Protect the rights, safety, and welfare of subjects involved in the research.
- 7) Submit to the IRB:
 - a) Proposed modifications as described in this manual. (See "[How do I submit a modification?](#)")
 - i) Single subject protocol exceptions should be submitted via the modification process.
 - b) A continuing review application as requested in the approval letter. (See "[How do I submit continuing review?](#)")
 - c) A continuing review application when the Human Research is closed. (See "[How Do I Close Out a Study?](#)")
- 8) Report any of the information items listed the section below, *What is a reportable event and how/when do I submit one?* within **five business days**.
- 9) Submit an updated disclosure of financial interests within thirty days of discovering or acquiring (e.g., through purchase, marriage, or inheritance) a new financial interest.
- 10) Do not accept or provide payments to professionals in exchange for referrals of potential subjects ("finder's fees."). Please see HRP-316- WORKSHEET – Payments.
- 11) Do not accept payments designed to accelerate recruitment that were tied to the rate or timing of enrollment ("bonus payments."). Please see HRP-316- WORKSHEET – Payments.
- 12) See additional requirements of various federal agencies in [Appendix A](#). These represent additional requirements and do not override the baseline requirements of this section.
- 13) If the study is a clinical trial and supported by a Common Rule agency, one IRB-approved version of a consent form that has been used to enroll participants must be posted on a public federal website designated for posting such consent forms. The form must be posted after recruitment closes, and no later than 60 days after the last study visit. Please contact the study sponsor with any questions.

- a) If certain information should not be made publicly available on a Federal website (e.g. confidential commercial information), the supporting Federal department or agency may permit or require redactions to the information posted. Contact the Federal department or agency supporting the clinical trial for a formal determination.
- b) Contact the supporting Federal department or agency sponsor with any other questions regarding consent form posting obligations.

What are my obligations as the overall study PI for an sIRB study?

- 1) Coordinate with HRPP personnel to determine reliance on an external IRB to assume oversight. The CCH IRB will not serve as a sIRB.
- 2) Identify all sites that will be engaged in the human research and requiring oversight by the IRB.
- 3) Ensure that all sites receive a request to rely on the reviewing IRB and that all institutional requirements are satisfied before a study is activated at a relying site.
- 4) Collaborate with the reviewing IRB to document roles and responsibilities for communicating and coordinating key information from study teams and the IRB or HRPP at relying sites.
- 5) Respond to questions or information requests from study teams or the IRB or HRPP staff at relying sites.
- 6) Provide relying site investigators with the policies of the reviewing IRB.
- 7) Provide relying site investigators with the IRB-approved versions of all study documents.
- 8) Help prepare and submit IRB applications on behalf of all sites. This includes initial review, modifications, personnel updates, reportable new information and continuing review information for all sites.
- 9) Establish a process for obtaining and collating information from all sites and submitting this information to the reviewing IRB. This includes site-specific variations in study conduct, such as the local consent process and language, subject identification and recruitment processes and local variations in study conduct.
- 10) Ensure that consent forms used by relying sites follow the consent template approved by the reviewing IRB and include required language as specified by the relying sites.
- 11) Provide site investigators with all determinations and communications from the reviewing IRB.
- 12) Submit reportable new information from relying sites to the reviewing IRB in accordance with the terms outlined in the authorization agreement or communication plan.

What are my obligations as investigator when relying on an external IRB?

- 1) Obtain appropriate approvals from this institution prior to seeking review by another IRB.
- 2) Comply with determinations and requirements of the reviewing IRB.
- 3) Provide the reviewing IRB with requested information about local requirements or local research context issues relevant to the IRB's determination prior to IRB review.
- 4) Notify the reviewing IRB when local policies that impact IRB review are updated.
- 5) Cooperate in the reviewing IRB's responsibility for initial and continuing review, record keeping and reporting and providing all information requested by the reviewing IRB in a timely manner.

- 6) Disclose conflicts of interest as required by the reviewing IRB and complying with management plans that may result.
- 7) Promptly report to the reviewing IRB any proposed changes to the research and not implementing those changes to the research without prior IRB review and approval, except where necessary to eliminate apparent immediate hazards to the participants.
- 8) When enrolling participants, obtain, document and maintain records of consent for each participant or each participant's legally authorized representative.
- 9) Promptly report to the reviewing IRB any unanticipated problems involving risks to participants or others according to the requirements specified in the reliance agreement.
- 10) Provide the reviewing IRB with data safety monitoring reports in accordance with the reviewing IRB's reporting policy.
- 11) Report non-compliance, participant complaints, protocol deviations or other events according to the requirements specified in the reliance agreement.
- 12) Specify the contact person and provide contact information for researchers and research staff to obtain answers to questions, express concerns, and convey suggestions regarding the use of the reviewing IRB.
- 13) You will receive notifications to submit an annual check in form. Submit an annual check in form to the CCH IRB in IRBManager at your approval anniversary date. You will receive an approval anniversary date that corresponds to the external IRBs expiration date. The continuing review approval letter from the external IRB must be included. The local approval date will be the day it was administratively approved by the CCH IRB.
- 14) The PI must inform the CCH IRB when the study has concluded using the HRP-212 Continuing Review/Closure form in IRBManager.
- 15) Any changes approved by the external IRB that in the opinion of the principal investigator indicate increased risk to participants and/or increased administrative burden on CCH resources must be submitted to the CCH IRB using HRP-213 - FORM - Modification. If changes are made to local site documents, including local consent documents, recruitment materials, or local study team members the investigator must update the site record using HRP-213 - FORM - Modification.
- 16) Local reportable new information must be reported to the CCH IRB when the reviewing IRB has determined that such information is an unanticipated problem and/or noncompliance on HRP-214 – FORM Reportable New Information.

How do I document consent?

Reference HRP-091-SOP-Written Documentation of Consent when documenting consent. Use the signature block approved by the IRB. Complete all items in the signature block, including dates and applicable checklists.

The following are the requirements for long form consent documents:

- The subject or representative signs and dates the consent document.
- The individual obtaining consent signs and dates the consent document.
- Whenever the IRB or the sponsor require a witness to the oral presentation, the witness signs and dates the consent document.

- For subjects who cannot read and whenever required by the IRB or the sponsor, a witness to the oral presentation signs and dates the consent document.
- A copy of the signed and dated consent document is to be provided to the subject.

The following are the requirements for short form consent documents:

- The subject or representative signs and dates the short form consent document.
- The individual obtaining consent signs and dates the summary.
- The witness to the oral presentation signs and dates the short form consent document and the summary.
- Copies of the signed and dated consent document and summary are provided to the person(s) signing those documents.

How do I submit a modification?

In order to create an amendment or modification for a currently approved study, first navigate to the study page in the IRBManager system. In the Actions on the left, select Start xForm and choose the amendment/modification submission form. Include any affected study related documents to the submission, including a tracked changes of the amended document and/or a summary of changes.

Please note that research must continue to be conducted without inclusion of the modification until IRB approval is received. Updates to the list of study personnel will be administratively approved unless the update represents a modification to the research, such as a PI change.

How do I submit continuing review?

In order to create a request for Continuing Approval for an existing study, first navigate to the study page in the IRBManager system. In the Actions on the left, select Start xForm and choose the progress report/closure submission form.

If the continuing review application is not received by the date requested in the approval letter, you will be restricted from submitting new Human Research until the completed application has been received.

If the approval of Human Research expires all Human Research procedures related to the protocol under review must cease, including recruitment, advertisement, screening, enrollment, consent, interventions, interactions, and collection or analysis of private identifiable information. Continuing Human Research procedures is a violation of institutional policy. If current subjects will be harmed by stopping Human Research procedures that are available outside the Human Research context, provide these on a clinical basis as needed to protect current subjects. If current subjects will be harmed by stopping Human Research procedures that are not available outside the Human Research context, immediately contact the IRB chair and provide a written list of the currently enrolled subjects and why they will be harmed by stopping Human Research procedures.

What is a reportable event and how/when do I submit one?

In order to submit a reportable event for an existing study, first navigate to the study page in the IRB Manager system. In the Actions on the left, select Start xForm and choose the reportable new information form. Report the information items that fall into one or more of the following categories to the IRB within 5 business days using the reportable new information form.

Information that does not fall under any of the categories does not require reporting to the IRB.

1. Information that indicates a new or increased risk, or a new safety issue. For example:
 - a. New information (e.g., an interim analysis, safety monitoring report, publication in the literature, sponsor report, or investigator finding) indicates an increase in the frequency or magnitude of a previously known risk, or uncovers a new risk.
 - b. An investigator brochure, package insert, or device labeling is revised to indicate an increase in the frequency or magnitude of a previously known risk, or describe a new risk
 - c. Withdrawal, restriction, or modification of a marketed approval of a drug, device, or biologic used in a research protocol
 - d. Protocol violation that harmed subjects or others or that indicates subjects or others might be at increased risk of harm
 - e. Complaint of a subject that indicates subjects or others might be at increased risk of harm or at risk of a new harm
 - f. Any changes significantly affecting the conduct of the research
2. Harm experienced by a subject or other individual, which in the opinion of the investigator are unexpected and probably related to the research procedures.
 - a. A harm is “unexpected” when its specificity or severity are inconsistent with risk information previously reviewed and approved by the IRB in terms of nature, severity, frequency, and characteristics of the study population.
 - b. A harm is “probably related” to the research procedures if in the opinion of the investigator, the research procedures more likely than not caused the harm.
3. Non-compliance with the federal regulations governing human research or with the requirements or determinations of the IRB, or an allegation of such non-compliance.
4. Audit, inspection, or inquiry by a federal agency and any resulting reports (e.g., FDA Form 483.)
5. Written reports of study monitors.
6. Failure to follow the protocol due to the action or inaction of the investigator or research staff.
7. Breach of confidentiality.
8. Change to the protocol taken without prior IRB review to eliminate an apparent immediate hazard to a subject.
9. Incarceration of a subject in a study not approved by the IRB to involve prisoners.
10. Complaint of a subject that cannot be resolved by the research team.
11. Premature suspension or termination of the protocol by the sponsor, investigator, or institution.
12. Unanticipated adverse device effect (any serious adverse effect on health or safety or any life-threatening problem or death caused by, or associated with, a device, if that effect, problem, or death was not previously identified in nature, severity, or degree of incidence in the investigational plan or application (including a supplementary plan or application), or any other unanticipated serious problem associated with a device that relates to the rights, safety, or welfare of subjects.)

How do I close out a study?

In order to create a request for closure of an existing study, first navigate to the study page in the IRB Manager system. In the Actions on the left, select Start xForm and choose the progress report/closure form.

If you fail to submit a continuing review form to close out Human Research, you will be restricted from submitting new Human Research until the completed closure form has been received.

How long do I keep records?

Maintain your Human Research records, including signed and dated consent documents for at least ten years after completion of the research. Maintain signed and dated HIPAA authorizations and consent documents that include HIPAA authorizations for at least ten years after completion of the research.

If your Human Research is sponsored contact the sponsor before disposing of Human Research records.

What if I need to use an unapproved drug, biologic, or device and there is no time for IRB review (Emergency Use)?

Contact the IRB Office or IRB chair immediately to discuss the situation. If there is no time to make this contact, see HRP-322 - WORKSHEET - Emergency Use for the regulatory criteria allowing such a use and make sure these are followed. Use HRP-506 - TEMPLATE CONSENT DOCUMENT - Emergency or Compassionate Device Use to prepare your consent document. You will need to submit a report of the use to the IRB within five working days of the use and for drugs and biologics, submit an IRB application for initial review within 30 days.

If you fail to submit the report within five working days or the IRB application for initial review within 30 days, you will be restricted from submitting new Human Research until the report and IRB application for initial review have been received.

Emergency use of an unapproved drug or biologic in a life-threatening situation without prior IRB review is “research” as defined by FDA, the individual getting the test article is a “subject” as defined by FDA, and therefore is governed by FDA regulations for IRB review and informed consent. Emergency use of an unapproved device without prior IRB review is not “research” as defined by FDA and the individual getting the test article is not a “subject” as defined by FDA. However, FDA guidance recommends following similar rules as for emergency use of an unapproved drug or biologic.

Individuals getting an unapproved drug, biologic, or device without prior IRB review cannot be considered a “subject” as defined by DHHS and their results cannot be included in prospective “research” as that term is defined by DHHS.

How do I get additional information and answers to questions?

This document and the policies and procedures for the Human Research Protection Program are available on the IRB Web Site at <https://cookcountyhealth.org/education-research/research/office-of-research-regulatory-affairs-irb/>

If you have any questions or concerns, about the Human Research Protection Program, contact the IRB Office at:

Betty Donoval JD MS
Director, Research & Regulatory Affairs
1950 W. Polk, Room 9303
Chicago, IL 60612
Email: bdonoval@cookcountyhhs.org
312- 864-4821

If you have questions, concerns, complaints, allegations of undue influence, allegations or findings of non-compliance, or input regarding the Human Research Protection Program that cannot be addressed by contacting the IRB Office, follow the directions in HRP-101 - HUMAN RESEARCH PROTECTION PROGRAM POLICY, CCH Policy #RA.011.01 under "Responsibilities of Institution Staff."

Appendix A-1 ***Additional Requirements for DHHS-Regulated Researchⁱⁱ***

1. When a subject decides to withdraw from a clinical trial, the investigator conducting the clinical trial should ask the subject to clarify whether the subject wishes to withdraw from all components of the trial or only from the primary interventional component of the trial. If the latter, research activities involving other components of the clinical trial, such as follow-up data collection activities, for which the subject previously gave consent may continue. The investigator should explain to the subject who wishes to withdraw the importance of obtaining follow-up safety data about the subject.
2. Investigators are allowed to retain and analyze already collected data relating to any subject who chooses to withdraw from a research study or whose participation is terminated by an investigator without regard to the subject's consent, provided such analysis falls within the scope of the analysis described in the IRB-approved protocol. This is the case even if that data includes identifiable private information about the subject.
3. For research not subject to regulation and review by FDA, investigators, in consultation with the funding agency, can choose to honor a research subject's request that the investigator destroy the subject's data or that the investigator exclude the subject's data from any analysis.
4. When seeking the informed consent of subjects, investigators should explain whether already collected data about the subjects will be retained and analyzed even if the subjects choose to withdraw from the research.
5. When research is covered by a certificate of confidentiality, researchers:
 - a. May not disclose or provide, in any Federal, State, or local civil, criminal, administrative, legislative, or other proceeding, the name of such individual or any such information, document, or biospecimen that contains identifiable, sensitive information about the individual and that was created or compiled for purposes of the research, unless such disclosure or use is made with the consent of the individual to whom the information, document, or biospecimen pertains; or
 - b. May not disclose or provide to any other person not connected with the research the name of such an individual or any information, document, or biospecimen that contains identifiable, sensitive information about such an individual and that was created or compiled for purposes of the research.
 - c. May disclose information only when:
 - i. Required by Federal, State, or local laws (e.g., as required by the Federal Food, Drug, and Cosmetic Act, or state laws requiring the reporting of communicable diseases to State and local health departments), excluding instances of disclosure in any Federal, State, or local civil, criminal, administrative, legislative, or other proceeding.
 - ii. Necessary for the medical treatment of the individual to whom the information, document, or biospecimen pertains and made with the consent of such individual;

- iii. Made with the consent of the individual to whom the information, document, or biospecimen pertains; or
 - iv. Made for the purposes of other scientific research that is in compliance with applicable Federal regulations governing the protection of human participants in research.
- d. Researchers must inform participants of the protections and limitations of certificates of confidentiality (see language in HRP-502 - TEMPLATE CONSENT DOCUMENT).
 - i. For studies that were previously issued a Certificate and notified participants of the protections provided by that Certificate, NIH does not expect participants to be notified that the protections afforded by the Certificate have changed, although IRBs may determine whether it is appropriate to inform participants.
 - ii. If part of the study cohort was recruited prior to issuance of the Certificate, but are no longer actively participating in the study, NIH does not expect participants consented prior to the change in authority, or prior to the issuance of a Certificate, to be notified that the protections afforded by the Certificate have changed, or that participants who were previously consented to be re-contacted to be informed of the Certificate, although the IRB may determine whether it is appropriate to inform participants.
- e. Researchers conducting research covered by a certificate of confidentiality, even if the research is not federally funded, must ensure that if identifiable, sensitive information is provided to other researchers or organizations, the other researcher or organization must comply with applicable requirements.

Appendix A-2 ***Additional Requirements for FDA-Regulated Research***

1. When a subject withdraws from a study:ⁱⁱⁱ
 - a. The data collected on the subject to the point of withdrawal remains part of the study database and may not be removed.
 - b. An investigator may ask a subject who is withdrawing whether the subject wishes to provide continued follow-up and further data collection subsequent to their withdrawal from the interventional portion of the study. Under this circumstance, the discussion with the subject would distinguish between study-related interventions and continued follow-up of associated clinical outcome information, such as medical course or laboratory results obtained through non-invasive chart review, and address the maintenance of privacy and confidentiality of the subject's information.
 - c. If a subject withdraws from the interventional portion of the study, but agrees to continued follow-up of associated clinical outcome information as described in the previous bullet, the investigator must obtain the subject's informed consent for this limited participation in the study (assuming such a situation was not described in the original informed consent form). IRB approval of informed consent documents is required.
 - d. If a subject withdraws from the interventional portion of a study and does not consent to continued follow-up of associated clinical outcome information, the investigator must not access for purposes related to the study the subject's medical record or other confidential records requiring the subject's consent.
 - e. An investigator may review study data related to the subject collected prior to the subject's withdrawal from the study, and may consult public records, such as those establishing survival status.
2. For FDA-regulated research involving investigational drugs:
 - a. Investigators must abide by FDA restrictions on promotion of investigational drugs:^{iv}
 - i. An investigator, or any person acting on behalf of an investigator, must not represent in a promotional context that an investigational new drug is safe or effective for the purposes for which it is under investigation or otherwise promote the drug.
 - ii. This provision is not intended to restrict the full exchange of scientific information concerning the drug, including dissemination of scientific findings in scientific or lay media. Rather, its intent is to restrict promotional claims of safety or effectiveness of the drug for a use for which it is under investigation and to preclude commercialization of the drug before it is approved for commercial distribution.
 - iii. An investigator must not commercially distribute or test market an investigational new drug.
 - b. Follow FDA requirements for general responsibilities of investigators^v
 - i. An investigator is responsible for ensuring that an investigation is conducted according to the signed investigator statement, the

- investigational plan, and applicable regulations; for protecting the rights, safety, and welfare of subjects under the investigator's care; and for the control of drugs under investigation.
- ii. An investigator must, in accordance with the provisions of 21 CFR §50, obtain the informed consent of each human subject to whom the drug is administered, except as provided in 21 CFR §50.23 or §50.24 of this chapter.
 - iii. Additional specific responsibilities of clinical investigators are set forth in this part and in 21 CFR §50 and 21 CFR §56.
- c. Follow FDA requirements for control of the investigational drug^{vi}
- i. An investigator must administer the drug only to subjects under the investigator's personal supervision or under the supervision of a sub-investigator responsible to the investigator.
 - ii. The investigator must not supply the investigational drug to any person not authorized under this part to receive it.
- d. Follow FDA requirements for investigator recordkeeping and record retention^{vii}
- i. Disposition of drug:
 - 1. An investigator is required to maintain adequate records of the disposition of the drug, including dates, quantity, and use by subjects.
 - 2. If the investigation is terminated, suspended, discontinued, or completed, the investigator must return the unused supplies of the drug to the sponsor, or otherwise provide for disposition of the unused supplies of the drug under 21 CFR §312.59.
 - ii. Case histories.
 - 1. An investigator is required to prepare and maintain adequate and accurate case histories that record all observations and other data pertinent to the investigation on each individual administered the investigational drug or employed as a control in the investigation.
 - 2. Case histories include the case report forms and supporting data including, for example, signed and dated consent forms and medical records including, for example, progress notes of the physician, the individual's hospital charts, and the nurses' notes. The case history for each individual must document that informed consent was obtained prior to participation in the study.
 - iii. Record retention: An investigator must retain required records for a period of 2 years following the date a marketing application is approved for the drug for the indication for which it is being investigated; or, if no application is to be filed or if the application is not approved for such indication, until 2 years after the investigation is discontinued and FDA is notified.
- e. Follow FDA requirements for investigator reports^{viii}
- i. Progress reports: The investigator must furnish all reports to the sponsor of the drug who is responsible for collecting and evaluating the results obtained.

- ii. Safety reports: An investigator must promptly report to the sponsor any adverse effect that may reasonably be regarded as caused by, or probably caused by, the drug. If the adverse effect is alarming, the investigator must report the adverse effect immediately.
 - iii. Final report: An investigator must provide the sponsor with an adequate report shortly after completion of the investigator's participation in the investigation.
 - iv. Financial disclosure reports:
 - 1. The clinical investigator must provide the sponsor with sufficient accurate financial information to allow an applicant to submit complete and accurate certification or disclosure statements as required under 21 CFR §54.
 - 2. The clinical investigator must promptly update this information if any relevant changes occur during the course of the investigation and for 1 year following the completion of the study.
 - f. Follow FDA requirements for assurance of IRB review^{ix}
 - i. An investigator must assure that an IRB that complies with the requirements set forth in 21 CFR §56 will be responsible for the initial and continuing review and approval of the proposed clinical study.
 - ii. The investigator must also assure that he or she will promptly report to the IRB all changes in the research activity and all unanticipated problems involving risk to human subjects or others, and that he or she will not make any changes in the research without IRB approval, except where necessary to eliminate apparent immediate hazards to human subjects.
 - g. Follow FDA requirements for inspection of investigator's records and reports^x
 - i. An investigator must upon request from any properly authorized officer or employee of FDA, at reasonable times, permit such officer or employee to have access to, and copy and verify any records or reports made by the investigator pursuant to 21 CFR §312.62.
 - ii. The investigator is not required to divulge subject names unless the records of particular individuals require a more detailed study of the cases, or unless there is reason to believe that the records do not represent actual case studies, or do not represent actual results obtained.
 - h. Follow FDA requirements for handling of controlled substances^{xi}
 - i. If the investigational drug is subject to the Controlled Substances Act, the investigator must take adequate precautions, including storage of the investigational drug in a securely locked, substantially constructed cabinet, or other securely locked, substantially constructed enclosure, access to which is limited, to prevent theft or diversion of the substance into illegal channels of distribution.
3. For FDA-regulated research involving investigational devices:
- a. General responsibilities of investigators.^{xii}
 - i. An investigator is responsible for ensuring that an investigation is conducted according to the signed agreement, the investigational plan

and applicable FDA regulations, for protecting the rights, safety, and welfare of subjects under the investigator's care, and for the control of devices under investigation. An investigator also is responsible for ensuring that informed consent is obtained in accordance with 21 CFR §50.

- b. Specific responsibilities of investigators^{xiii}
 - i. Awaiting approval: An investigator may determine whether potential subjects would be interested in participating in an investigation, but must not request the written informed consent of any subject to participate, and must not allow any subject to participate before obtaining IRB and FDA approval.
 - ii. Compliance: An investigator must conduct an investigation in accordance with the signed agreement with the sponsor, the investigational plan, and other applicable FDA regulations, and any conditions of approval imposed by an IRB or FDA.
 - iii. Supervising device use: An investigator must permit an investigational device to be used only with subjects under the investigator's supervision. An investigator must not supply an investigational device to any person not authorized to receive it.
 - iv. Financial disclosure:
 - 1. A clinical investigator must disclose to the sponsor sufficient accurate financial information to allow the applicant to submit complete and accurate certification or disclosure statements required under 21 CFR §54.
 - 2. The investigator must promptly update this information if any relevant changes occur during the course of the investigation and for 1 year following completion of the study.
 - v. Disposing of device: Upon completion or termination of a clinical investigation or the investigator's part of an investigation, or at the sponsor's request, an investigator must return to the sponsor any remaining supply of the device or otherwise dispose of the device as the sponsor directs.
- c. Maintain the following accurate, complete, and current records relating to the investigator's participation in an investigation:^{xiv}
 - i. All correspondence with another investigator, an IRB, the sponsor, a monitor, or FDA, including required reports.
 - ii. Records of receipt, use or disposition of a device that relate to:
 - 1. The type and quantity of the device, the dates of its receipt, and the batch number or code mark.
 - 2. The names of all persons who received, used, or disposed of each device.
 - 3. Why and how many units of the device have been returned to the sponsor, repaired, or otherwise disposed of.
 - iii. Records of each subject's case history and exposure to the device. Case histories include the case report forms and supporting data including, for

example, signed and dated consent forms and medical records including, for example, progress notes of the physician, the individual's hospital charts, and the nurses' notes. Such records must include:

1. Documents evidencing informed consent and, for any use of a device by the investigator without informed consent, any written concurrence of a licensed physician and a brief description of the circumstances justifying the failure to obtain informed consent.
 2. Documentation that informed consent was obtained prior to participation in the study.
 3. All relevant observations, including records concerning adverse device effects (whether anticipated or unanticipated), information and data on the condition of each subject upon entering, and during the course of, the investigation, including information about relevant previous medical history and the results of all diagnostic tests.
 4. A record of the exposure of each subject to the investigational device, including the date and time of each use, and any other therapy.
- iv. The protocol, with documents showing the dates of and reasons for each deviation from the protocol.
- v. Any other records that FDA requires to be maintained by regulation or by specific requirement for a category of investigations or a particular investigation.
- d. Inspections^{xv}
- i. Entry and inspection: A sponsor or an investigator who has authority to grant access must permit authorized FDA employees, at reasonable times and in a reasonable manner, to enter and inspect any establishment where devices are held (including any establishment where devices are manufactured, processed, packed, installed, used, or implanted or where records of results from use of devices are kept).
 - ii. Records inspection: A sponsor, IRB, or investigator, or any other person acting on behalf of such a person with respect to an investigation, must permit authorized FDA employees, at reasonable times and in a reasonable manner, to inspect and copy all records relating to an investigation.
 - iii. Records identifying subjects: An investigator must permit authorized FDA employees to inspect and copy records that identify subjects, upon notice that FDA has reason to suspect that adequate informed consent was not obtained, or that reports required to be submitted by the investigator to the sponsor or IRB have not been submitted or are incomplete, inaccurate, false, or misleading.
- e. Prepare and submit the following complete, accurate, and timely reports^{xvi}
- i. Unanticipated adverse device effects. An investigator must submit to the sponsor and to the reviewing IRB a report of any unanticipated adverse device effect occurring during an investigation as soon as possible, but in

- no event later than 10 working days after the investigator first learns of the effect.
- ii. Withdrawal of IRB approval. An investigator must report to the sponsor, within 5 working days, a withdrawal of approval by the reviewing IRB of the investigator's part of an investigation.
 - iii. Progress. An investigator must submit progress reports on the investigation to the sponsor, the monitor, and the reviewing IRB at regular intervals, but in no event less often than yearly.
 - iv. Deviations from the investigational plan:
 - 1. An investigator must notify the sponsor and the reviewing IRB of any deviation from the investigational plan to protect the life or physical well-being of a subject in an emergency.
 - 2. Such notice must be given as soon as possible, but in no event later than 5 working days after the emergency occurred.
 - 3. Except in such an emergency, prior approval by the sponsor is required for changes in or deviations from a plan, and if these changes or deviations may affect the scientific soundness of the plan or the rights, safety, or welfare of human subjects, FDA and IRB approval are also required.
 - v. Informed consent. If an investigator uses a device without obtaining informed consent, the investigator must report such use to the sponsor and the reviewing IRB within 5 working days after the use occurs.
 - vi. Final report. An investigator must, within 3 months after termination or completion of the investigation or the investigator's part of the investigation, submit a final report to the sponsor and the reviewing IRB.
 - vii. Other. An investigator must, upon request by a reviewing IRB or FDA, provide accurate, complete, and current information about any aspect of the investigation.

Appendix A-3 ***Additional Requirements for Clinical Trials (ICH-GCP)***

1. Investigator's Qualifications and Agreements
 - a. The clinical trial should be conducted in accordance with the ethical principles that have their origin in the Declaration of Helsinki and that are consistent with good clinical practice and the applicable regulatory requirements.
 - b. The investigator should be qualified by education, training, and experience to assume responsibility for the proper conduct of the trial, should meet all the qualifications specified by the applicable regulatory requirements, and should provide evidence of such qualifications through up-to-date curriculum vitae and/or other relevant documentation requested by the sponsor, the IRB, and/or the regulatory authorities.
 - c. The investigator should be thoroughly familiar with the appropriate use of the investigational product, as described in the protocol, in the current Investigator's Brochure, in the product information and in other information sources provided by the sponsor.
 - d. The investigator should be aware of, and should comply with, GCP and the applicable regulatory requirements.
 - e. The investigator/institution should permit monitoring and auditing by the sponsor, and inspection by the appropriate regulatory authorities.
 - f. The investigator should maintain a list of appropriately qualified persons to whom the investigator has delegated significant trial-related duties.
2. Adequate Resources
 - a. The investigator should be able to demonstrate (e.g., based on retrospective data) a potential for recruiting the required number of suitable subjects within the agreed recruitment period.
 - b. The investigator should have sufficient time to properly conduct and complete the trial within the agreed trial period.
 - c. The investigator should have available an adequate number of qualified staff and adequate facilities for the foreseen duration of the trial to conduct the trial properly and safely.
 - d. The investigator should ensure that all persons assisting with the trial are adequately informed about the protocol, the investigational product, and their trial-related duties and functions.
3. Medical Care of Trial Subjects
 - a. A qualified physician (or dentist, when appropriate), who is an investigator or a sub-investigator for the trial, should be responsible for all trial-related medical (or dental) decisions.
 - b. During and following a subject's participation in a trial, the investigator/institution should ensure that adequate medical care is provided to a subject for any adverse events, including clinically significant laboratory values, related to the trial. The investigator/institution should inform a subject when medical care is needed for intercurrent illnesses of which the investigator becomes aware.

- c. It is recommended that the investigator inform the subject's primary physician about the subject's participation in the trial if the subject has a primary physician and if the subject agrees to the primary physician being informed.
 - d. Although a subject is not obliged to give his/her reasons for withdrawing prematurely from a trial, the investigator should make a reasonable effort to ascertain the reasons, while fully respecting the subject's rights.
- 4. Communication with IRB
 - a. Before initiating a trial, the investigator/institution should have written and dated approval opinion from the IRB for the trial protocol, written informed consent form, consent form updates, subject recruitment procedures (e.g., advertisements), and any other written information to be provided to subjects.
 - b. As part of the investigator's/institution's written application to the IRB, the investigator/institution should provide the IRB with a current copy of the Investigator's Brochure. If the Investigator's Brochure is updated during the trial, the investigator/institution should supply a copy of the updated Investigator's Brochure to the IRB.
 - c. During the trial the investigator/institution should provide to the IRB all documents subject to review.
- 5. Compliance with Protocol
 - a. The investigator/institution should conduct the trial in compliance with the protocol agreed to by the sponsor and, if required, by the regulatory authorities and which was given approval opinion by the IRB. The investigator/institution and the sponsor should sign the protocol, or an alternative contract, to confirm agreement.
 - b. The investigator should not implement any deviation from, or changes of the protocol without agreement by the sponsor and prior review and documented approval opinion from the IRB of an amendment, except where necessary to eliminate an immediate hazards to trial subjects, or when the changes involves only logistical or administrative aspects of the trial (e.g., change in monitors, change of telephone numbers).
 - c. The investigator, or person designated by the investigator, should document and explain any deviation from the approved protocol.
 - d. The investigator may implement a deviation from, or a change of, the protocol to eliminate an immediate hazard to trial subjects without prior IRB approval opinion. As soon as possible, the implemented deviation or change, the reasons for it, and, if appropriate, the proposed protocol amendments should be submitted: a) to the IRB for review and approval opinion, b) to the sponsor for agreement and, if required, c) to the regulatory authorities.
- 6. Investigational Product
 - a. Responsibility for investigational product accountability at the trial site rests with the investigator/institution.
 - b. Where allowed/required, the investigator/institution may/should assign some or all of the investigator's/institution's duties for investigational product accountability at the trial site to an appropriate pharmacist or another appropriate individual who is under the supervision of the investigator/institution.

- c. The investigator/institution and/or a pharmacist or other appropriate individual, who is designated by the investigator/institution, should maintain records of the product's delivery to the trial site, the inventory at the site, the use by each subject, and the return to the sponsor or alternative disposition of unused product. These records should include dates, quantities, batch/serial numbers, expiration dates (if applicable), and the unique code numbers assigned to the investigational product and trial subjects. Investigators should maintain records that document adequately that the subjects were provided the doses specified by the protocol and reconcile all investigational product received from the sponsor.
 - d. The investigational product should be stored as specified by the sponsor and in accordance with applicable regulatory requirements.
 - e. The investigator should ensure that the investigational product is used only in accordance with the approved protocol.
 - f. The investigator, or a person designated by the investigator/institution, should explain the correct use of the investigational product to each subject and should check, at intervals appropriate for the trial, that each subject is following the instructions properly.
 - g. Randomization Procedures and Unblinding: The investigator should follow the trial's randomization procedures, if any, and should ensure that the code is broken only in accordance with the protocol. If the trial is blinded, the investigator should promptly document and explain to the sponsor any premature unblinding (e.g., accidental unblinding, unblinding due to a serious adverse event) of the investigational product.
7. Informed Consent of Trial Subjects
- a. In obtaining and documenting informed consent, the investigator should comply with the applicable regulatory requirements, and should adhere to GCP and to the ethical principles that have their origin in the Declaration of Helsinki. Prior to the beginning of the trial, the investigator should have the IRB's written approval opinion of the written informed consent form and any other written information to be provided to subjects.
 - b. The written informed consent form and any other written information to be provided to subjects should be revised whenever important new information becomes available that may be relevant to the subject's consent. Any revised written informed consent form, and written information should receive the IRB's approval opinion in advance of use. The subject or the subject's legally acceptable representative should be informed in a timely manner if new information becomes available that may be relevant to the subject's willingness to continue participation in the trial. The communication of this information should be documented.
 - c. Neither the investigator, nor the trial staff, should coerce or unduly influence a subject to participate or to continue to participate in a trial.
 - d. None of the oral and written information concerning the trial, including the written informed consent form, should contain any language that causes the subject or the subject's legally acceptable representative to waive or to appear to waive any

legal rights, or that releases or appears to release the investigator, the institution, the sponsor, or their agents from liability for negligence.

- e. The investigator, or a person designated by the investigator, should fully inform the subject or, if the subject is unable to provide informed consent, the subject's legally acceptable representative, of all pertinent aspects of the trial including the written information and the approval opinion by the IRB.
- f. The language used in the oral and written information about the trial, including the written informed consent form, should be as non-technical as practical and should be understandable to the subject or the subject's legally acceptable representative and the impartial witness, where applicable.
- g. Before informed consent may be obtained, the investigator, or a person designated by the investigator, should provide the subject or the subject's legally acceptable representative ample time and opportunity to inquire about details of the trial and to decide whether or not to participate in the trial. All questions about the trial should be answered to the satisfaction of the subject or the subject's legally acceptable representative.
- h. Prior to a subject's participation in the trial, the written informed consent form should be signed and personally dated by the subject or by the subject's legally acceptable representative, and by the person who conducted the informed consent discussion. If using a Short Form Consent, please reference HRP-317 – WORKSHEET – Short Form of Consent Documentation.
- i. If a subject is unable to read or if a legally acceptable representative is unable to read, an impartial witness should be present during the entire informed consent discussion. After the written informed consent form and any other written information to be provided to subjects, is read and explained to the subject or the subject's legally acceptable representative, and after the subject or the subject's legally acceptable representative has orally consented to the subject's participation in the trial and, if capable of doing so, has signed and personally dated the informed consent form, the witness should sign and personally date the consent form. By signing the consent form, the witness attests that the information in the consent form and any other written information was accurately explained to, and apparently understood by, the subject or the subject's legally acceptable representative, and that informed consent was freely given by the subject or the subject's legally acceptable representative.
- j. Both the informed consent discussion and the written informed consent form and any other written information to be provided to subjects should include explanations of the following:
 - i. That the trial involves research.
 - ii. The purpose of the trial.
 - iii. The trial treatments and the probability for random assignment to each treatment.
 - iv. The trial procedures to be followed, including all invasive procedures.
 - v. The subject's responsibilities.
 - vi. Those aspects of the trial that are experimental.

- vii. The reasonably foreseeable risks or inconveniences to the subject and, when applicable, to an embryo, fetus, or nursing infant.
 - viii. The reasonably expected benefits. When there is no intended clinical benefit to the subject, the subject should be made aware of this.
 - ix. The alternative procedures or courses of treatment that may be available to the subject, and their important potential benefits and risks.
 - x. The compensation and/or treatment available to the subject in the event of trial related injury.
 - xi. The anticipated prorated payment, if any, to the subject for participating in the trial.
 - xii. The anticipated expenses, if any, to the subject for participating in the trial.
 - xiii. That the subject's participation in the trial is voluntary and that the subject may refuse to participate or withdraw from the trial, at any time, without penalty or loss of benefits to which the subject is otherwise entitled.
 - xiv. That the monitors, the auditors, the IRB, and the regulatory authorities will be granted direct access to the subject's original medical records for verification of clinical trial procedures and/or data, without violating the confidentiality of the subject, to the extent permitted by the applicable laws and regulations and that, by signing a written informed consent form, the subject or the subject's legally acceptable representative is authorizing such access.
 - xv. That records identifying the subject will be kept confidential and, to the extent permitted by the applicable laws and/or regulations, will not be made publicly available. If the results of the trial are published, the subject's identity will remain confidential.
 - xvi. That the subject or the subject's legally acceptable representative will be informed in a timely manner if information becomes available that may be relevant to the subject's willingness to continue participation in the trial.
 - xvii. The persons to contact for further information regarding the trial and the rights of trial subjects, and whom to contact in the event of trial-related injury.
 - xviii. The foreseeable circumstances and/or reasons under which the subject's participation in the trial may be terminated.
 - xix. The expected duration of the subject's participation in the trial.
 - xx. The approximate number of subjects involved in the trial.
 - xxi. The language about the trial being posted to clinicaltrials.gov.
 - xxii. The consequences of the subject's decision to withdraw from the study and procedures for orderly termination of participation by the subject.
 - xxiii. A statement that the particular treatment or procedure may involve risks to the subject (or to the embryo or fetus, if the subject is or may become pregnant), which are currently unforeseeable.
- k. Prior to participation in the trial, the subject or the subject's legally acceptable representative should receive a copy of the signed and dated written informed consent form and any other written information provided to the subjects. During a

designated representatives on making such corrections. Sponsors should have written procedures to assure that changes or corrections in CRFs made by sponsor's designated representatives are documented, are necessary, and are endorsed by the investigator. The investigator should retain records of the changes and corrections.

- d. The investigator/institution should maintain the trial documents as specified in Essential Documents for the Conduct of a Clinical Trial and as required by the applicable regulatory requirements. The investigator/institution should take measures to prevent accidental or premature destruction of these documents.
 - e. Essential documents should be retained until at least 2 years after the last approval of a marketing application in an ICH region and until there are no pending or contemplated marketing applications in an ICH region or at least 2 years have elapsed since the formal discontinuation of clinical development of the investigational product. These documents should be retained for a longer period however if required by the applicable regulatory requirements or by an agreement with the sponsor. It is the responsibility of the sponsor to inform the investigator/institution as to when these documents no longer need to be retained.
 - f. The financial aspects of the trial should be documented in an agreement between the sponsor and the investigator/institution.
 - g. Upon request of the monitor, auditor, IRB, or regulatory authority, the investigator/institution should make available for direct access all requested trial-related records.
9. Progress Reports
- a. The investigator should submit written summaries of the trial status to the IRB annually, or more frequently, if requested by the IRB.
 - b. The investigator should promptly provide written reports to the sponsor, the IRB and, where applicable, the institution on any changes significantly affecting the conduct of the trial, and/or increasing the risk to subjects.
10. Safety Reporting
- a. All serious adverse events (SAEs) should be reported immediately to the sponsor except for those SAEs that the protocol or other document (e.g., Investigator's Brochure) identifies as not needing immediate reporting. The immediate reports should be followed promptly by detailed, written reports. The immediate and follow-up reports should identify subjects by unique code numbers assigned to the trial subjects rather than by the subjects' names, personal identification numbers, and/or addresses. The investigator should also comply with the applicable regulatory requirements related to the reporting of unexpected serious adverse drug reactions to the regulatory authorities and the IRB.
 - b. Adverse events and/or laboratory abnormalities identified in the protocol as critical to safety evaluations should be reported to the sponsor according to the reporting requirements and within the time periods specified by the sponsor in the protocol.

- c. For reported deaths, the investigator should supply the sponsor and the IRB with any additional requested information (e.g., autopsy reports and terminal medical reports).
 - d. Premature Termination or Suspension of a Trial If the trial is prematurely terminated or suspended for any reason, the investigator/institution should promptly inform the trial subjects, should assure appropriate therapy and follow-up for the subjects, and, where required by the applicable regulatory requirements, should inform the regulatory authorities. In addition:
 - i. If the investigator terminates or suspends a trial without prior agreement of the sponsor, the investigator should inform the institution where applicable, and the investigator/institution should promptly inform the sponsor and the IRB, and should provide the sponsor and the IRB a detailed written explanation of the termination or suspension.
 - ii. If the sponsor terminates or suspends a trial, the investigator should promptly inform the institution where applicable and the investigator/institution should promptly inform the IRB and provide the IRB a detailed written explanation of the termination or suspension.
 - iii. If the IRB terminates or suspends its approval opinion of a trial, the investigator should inform the institution where applicable and the investigator/institution should promptly notify the sponsor and provide the sponsor with a detailed written explanation of the termination or suspension.
11. Final Reports by Investigator: Upon completion of the trial, the investigator, where applicable, should inform the institution; the investigator/institution should provide the IRB with a summary of the trial's outcome, and the regulatory authorities with any reports required.

Appendix A-4 ***Additional Requirements for Department of Defense (DOD) research***

1. When appropriate, research protocols must be reviewed and approved by the IRB prior to the Department of Defense approval. Consult with the Department of Defense funding component to see whether this is a requirement.
2. Civilian researchers attempting to access military volunteers should seek collaboration with a military researcher familiar with service-specific requirements.
3. Employees of the Department of Defense (including temporary, part-time, and intermittent appointments) may not be able to legally accept payments to participate in research and should check with their supervisor before accepting such payments. Employees of the Department of Defense cannot be paid for conducting research while on active duty.
4. Service members must follow their command policies regarding the requirement to obtain command permission to participate in research involving human subjects while on-duty or off-duty.
5. Components of the Department of Defense might have stricter requirements for research-related injury than the DHHS regulations.
6. There may be specific educational requirements or certification required.
7. When assessing whether to support or collaborate with this institution for research involving human subjects, the Department of Defense may evaluate this institution's education and training policies to ensure the personnel are qualified to perform the research.
8. When research involves U.S. military personnel, policies and procedures require limitations on dual compensation:
 - a. Prohibit an individual from receiving pay of compensation for research during duty hours.
 - b. An individual may be compensated for research if the participant is involved in the research when not on duty.
 - c. Federal employees while on duty and non-Federal persons may be compensated for blood draws for research up to \$50 for each blood draw.
 - d. Non-Federal persons may be compensated for research participating other than blood draws in a reasonable amount as approved by the IRB according to local prevailing rates and the nature of the research.
9. Surveys performed on DOD personnel must be submitted, reviewed, and approved by the DOD Information Management Control Officer (IMCO) after the research protocol is reviewed and approved by the IRB. When a survey crosses DOD components, additional review is required. Consult the Department of Defense funding component to coordinate this review.
10. When research involves large scale genomic data (LSGD) collected on DOD-affiliated personnel, additional protections are required:

- a. Additional administrative, technical, and physical safeguards to prevent disclosure of DoD-affiliated personnel's genomic data commensurate with risk (including secondary use or sharing of de-identified data or specimens)
 - b. Research will apply an HHS Certificate of Confidentiality
 - c. DoD Component security review
- 11. Data or information sent to a DOD component under a pledge of confidentiality for exclusively statistical purposes must be used exclusively for statistical purposes and may not be disclosed in identifiable form for any other purpose, except with the informed consent of the respondent.
- 12. When conducting multi-site research, a formal agreement between institutions is required to specify the roles and responsibilities of each party.
- 13. The following must be reported to the applicable DOD Component Office of Human Research Protections within 30 days:
 - a. When significant changes to the research protocol are approved by the IRB or EC:
 - i. Changes to key investigators or institutions.
 - ii. Decreased benefit or increased risk to participants in greater than minimal risk research.
 - iii. Addition of vulnerable populations as participants.
 - iv. Addition of DOD-affiliated personnel as participants.
 - v. Change of reviewing IRB.
 - b. When the organization is notified by any federal body, state agency, official governing body of a Native American or Alaskan native tribe, other entity, or foreign government that any part of an HRPP is under investigation for cause involving a DOD-supported research protocol.
 - c. Any problems involving risks to participants or others, suspension or termination of IRB approval, or any serious or continuing noncompliance pertaining to DOD-supported human participant research.
 - d. The results of the IRB's continuing review, if required.
 - e. Change in status when a previously enrolled participant becomes pregnant, or when the researcher learns that a previously enrolled participant is pregnant, and the protocol was not reviewed and approved by the IRB in accordance with 45 CFR 46, Subpart B.
 - f. Change in status when a previously enrolled participant becomes a prisoner, and the protocol was not reviewed and approved by the IRB in accordance with 32 CFR 219, Subpart C.
 - g. Closure of a DOD-supported study.
- 14. For human participant research that would not otherwise be approved but presents an opportunity to understand, prevent, or alleviate a serious problem affecting the health or welfare of pregnant women, fetuses, or neonates, written approval from the DOD Office for Human Research Protections must be obtained through the DOD Component Office of Human Research Protections prior to research starting.
- 15. Other specific requirements of the Department of Defense research be found in the "Additional Requirements for Department of Defense (DOD) Research" section in the IRB's HRP-318 - WORKSHEET - Additional Federal Agency Criteria.

Appendix A-5 *Additional Requirements for Department of Energy (DOE) Research*

(See DOE Order 443.1C)

1. Research that involves one or more of the following must be submitted to the appropriate IRB for human subjects research review and determination :
 - a. Study of humans in a systematically modified environment. These studies include but are not limited to intentional modification of the human environment:
 - i. Study of human environments that use tracer chemicals, particles or other materials to characterize airflow.
 - ii. Study in occupied homes or offices that:
 1. Manipulate the environment to achieve research aims.
 2. Test new materials.
 3. Involve collecting information on occupants' views of appliances, materials, or devices installed in their homes or their energy-saving behaviors through surveys and focus groups.
 - b. Use of social media data.
 - c. Human Terrain Mapping (HTM).
 - d. All exempt HSR determinations must be made by the appropriate IRB and/or IRB office.
2. Personally identifiable information collected and/or used during HSR projects must be protected in accordance with the requirements of DOE Order 206.1, Department of Energy Privacy Program, current version. The Central DOE IRBs require submission of DOE's HRP- 490-CHECKLIST-Reviewing Protocols that use Personally Identifiable Information (PII) if your research includes PII.
3. You must report the following to the DOE human subjects research Program Manager (and, when an NNSA element is involved, the NNSA HSP Program Manager) prior to initiation of any new human subjects research project, even if it meets the regulatory definition of exempt human subjects research as outlined in 10 CFR Part 745.104, involving:
 - a. An institution without an established Institutional Review Board (IRB);
 - b. A foreign country;
 - c. The potential for significant controversy (e.g., negative press or reaction from stakeholder or oversight groups);
 - d. Research subjects in a protected class (prisoners, children, individuals with impaired decision making capability, or DOE/NNSA federal or DOE/NNSA contractor employees as human subjects, who may be more vulnerable to coercion and undue influence to participate) that is outside of the reviewing IRB's typical range/scope; or
 - e. The generation or use of classified information.
4. The IRB must be notified immediately and the DOE HSP Program Manager (and, when an NNSA element is involved, the NNSA HSP Program Manager) must be notified within 48 hours and consulted regarding planned corrective actions if any of the following occur:

- a. Adverse events. Notify the IRB for all adverse events and the DOE/NNSA HSP Program Manager if the IRB determines them to be significant, as defined in DOE Order 443.1C.
 - b. Unanticipated problems and complaints about the research.
 - c. Any suspension or termination of IRB approval of research.
 - d. Any significant non-compliance with HSP Program procedures or other requirements.
 - e. Any finding of a suspected or confirmed data breach involving PII in printed or electronic form. Report immediately to the IRB, the DOE/NNSA HSP Program Manager(s), and the DOE-Cyber Incident Response Capability, in accordance with the requirements of the CRD associated with DOE O 206.1.
 - f. Serious adverse events and corrective actions taken must be reported immediately to the IRB and the DOE/NNSA HSP Program Manager(s). The time frame for “immediately” is defined as upon discovery.
5. Requirements for human participant protections for classified research apply to all classified research conducted or supported by the DOE and its national laboratories, including contracts, and including Human Terrain Mapping research.
 6. Researchers conducting human subjects research in any other country or on citizens or other individuals residing in that country must be cognizant of country-specific human subjects research requirements and consult the IRB regarding applicability of such requirements.
 7. No human subjects research conducted with DOE funding, at DOE institutions (regardless of funding source), or by DOE or DOE contractor personnel (regardless of funding source or location conducted), whether done domestically or in an international environment, including classified and proprietary research, may be initiated without both a Federalwide Assurance (FWA) or comparable assurance (e.g., Department of Defense assurance) of compliance and approval by the cognizant Institutional Review Board (IRB) in accordance with 10 CFR §745.103. Human subjects research involving multiple DOE sites (e.g., members of the research team from more than one DOE site and/or data or human subjects from more than one DOE site) must be reviewed and approved by one of the Central DOE IRBs prior to initiation, or if authorized by the DOE and/or NNSA HSP Program Manager, other appropriate IRB of record. In all cases, an IRB Authorization Agreement (IAA) or Memorandum of Understanding (MOU) must be in place between the organization(s) conducting the HSR and the organization responsible for IRB review.
 8. Human subjects research that involves DOE Federal and/or contractor employees must first be reviewed and approved by the appropriate DOE IRB (the DOE site IRB or one of the Central DOE IRBs), or if deemed more fitting by the Federally assured DOE site or Headquarters, other appropriate IRB of record, in accordance with an IAA or MOU negotiated between the DOE site or Headquarters and the organization responsible for IRB review.
 9. Classified and unclassified human subjects research that is funded through the Strategic Intelligence Partnership Program (SIPP) must be reviewed and approved by the Central DOE IRB-Classified.

10. If applicable, federally funded HSR must comply with the requirements of the Paperwork Reduction Act.
11. Other specific requirements of the DOE research can be found in the “Additional Requirements for Department of Energy (DOE) Research” section in the IRB’s HRP-318 - WORKSHEET - Additional Federal Agency Criteria.

Appendix A-6 *Additional Requirements for Department of Justice (DOJ) Research*

Additional Requirements for DOJ Research conducted in the Federal Bureau of Prisons

1. Implementation of Bureau programmatic or operational initiatives made through pilot projects is not considered to be research.
2. The project must not involve medical experimentation, cosmetic research, or pharmaceutical testing.
3. The research design must be compatible with both the operation of prison facilities and protection of human subjects.
4. Investigators must observe the rules of the institution or office in which the research is conducted.
5. Any investigator who is a non-employee of the Bureau of Prisoners must sign a statement in which the investigator agrees to adhere to the requirements of 28 CFR §512.
6. The research must be reviewed and approved by the Bureau Research Review Board.
7. Incentives cannot be offered to help persuade inmate subjects to participate. However, soft drinks and snacks to be consumed at the test setting may be offered. Reasonable accommodations such as nominal monetary recompense for time and effort may be offered to non-confined research subjects who are both: No longer in Bureau of Prisons custody. Participating in authorized research being conducted by Bureau employees or contractors.
8. A non-employee of the Bureau may receive records in a form not individually identifiable when advance adequate written assurance that the record will be used solely as a statistical research or reporting record is provided to the agency.
9. Except as noted in the consent statement to the subject, you must not provide research information that identifies a subject to any person without that subject's prior written consent to release the information. For example, research information identifiable to a particular individual cannot be admitted as evidence or used for any purpose in any action, suit, or other judicial, administrative, or legislative proceeding without the written consent of the individual to whom the data pertain.
10. Except for computerized data records maintained at an official Department of Justice site, records that contain non-disclosable information directly traceable to a specific person may not be stored in, or introduced into, an electronic retrieval system.
11. If you are conducting a study of special interest to the Office of Research and Evaluation but the study is not a joint project involving Office of Research and Evaluation, you may be asked to provide Office of Research and Evaluation with the computerized research data, not identifiable to individual subjects, accompanied by detailed documentation. These arrangements must be negotiated prior to the beginning of the data collection phase of the project.
12. Required elements of disclosure additionally include:
 - a. Identification of the investigators.
 - b. Anticipated uses of the results of the research.

- c. A statement that participation is completely voluntary and that the subject may withdraw consent and end participation in the project at any time without penalty or prejudice (the inmate will be returned to regular assignment or activity by staff as soon as practicable).
 - d. A statement regarding the confidentiality of the research information and exceptions to any guarantees of confidentiality required by federal or state law. For example, an investigator may not guarantee confidentiality when the subject indicates intent to commit future criminal conduct or harm himself or herself or someone else, or, if the subject is an inmate, indicates intent to leave the facility without authorization.
 - e. A statement that participation in the research project will have no effect on the inmate subject's release date or parole eligibility.
13. You must have academic preparation or experience in the area of study of the proposed research.
14. The IRB application must include a summary statement, which includes:
- a. Names and current affiliations of the investigators.
 - b. Title of the study.
 - c. Purpose of the study.
 - d. Location of the study.
 - e. Methods to be employed.
 - f. Anticipated results.
 - g. Duration of the study.
 - h. Number of subjects (staff or inmates) required and amount of time required from each.
 - i. Indication of risk or discomfort involved as a result of participation.
15. The IRB application must include a comprehensive statement, which includes:
- a. Review of related literature.
 - b. Detailed description of the research method.
 - c. Significance of anticipated results and their contribution to the advancement of knowledge.
 - d. Specific resources required from the Bureau of Prisons.
 - e. Description of all possible risks, discomforts, and benefits to individual subjects or a class of subjects, and a discussion of the likelihood that the risks and discomforts will actually occur.
 - f. Description of steps taken to minimize any risks.
 - g. Description of physical or administrative procedures to be followed to: Ensure the security of any individually identifiable data that are being collected for the study.
 - h. Destroy research records or remove individual identifiers from those records when the research has been completed.
 - i. Description of any anticipated effects of the research study on institutional programs and operations.
 - j. Relevant research materials such as vitae, endorsements, sample consent statements, questionnaires, and interview schedules.
16. The IRB application must include a statement regarding assurances and certification required by federal regulations, if applicable.

17. You must assume responsibility for actions of any person engaged to participate in the research project as an associate, assistant, or subcontractor.
18. At least once a year, you must provide the Chief, Office of Research and Evaluation, with a report on the progress of the research.
19. At least 12 working days before any report of findings is to be released, you must distribute one copy of the report to each of the following: the chairperson of the Bureau Research Review Board, the regional director, and the warden of each institution that provided data or assistance.
20. You must include an abstract in the report of findings.
21. In any publication of results, you must acknowledge the Bureau's participation in the research project.
22. You must expressly disclaim approval or endorsement of the published material as an expression of the policies or views of the Bureau.
23. Prior to submitting for publication the results of a research project conducted under this subpart, You must provide two copies of the material, for informational purposes only, to the Chief, Office of Research and Evaluation, Central Office, Bureau of Prisons.
24. Other specific requirements of the Department of Justice (DOJ) Research Conducted within the Federal Bureau of Prisons (BOP) can be found in the "Additional Requirements for Department of Justice (DOJ) Research Conducted within the Federal Bureau of Prisons (BOP)" section in the IRB's HRP-318 - WORKSHEET - Additional Federal Agency Criteria.

Additional Requirements for DOJ Research Funded by the National Institute of Justice

1. The project must have a privacy certificate approved by the National Institute of Justice Human Subjects Protection Officer.
2. All investigators and research staff are required to sign employee confidentiality statements, which are maintained by the responsible investigator.
3. The confidentiality statement on the consent document must state that confidentiality can only be broken if the subject reports immediate harm to subjects or others.
4. Under a privacy certificate, investigators and research staff do not have to report child abuse unless the subject signs another consent document to allow child abuse reporting.
5. A copy of all data must be de-identified and sent to the National Archive of Criminal Justice Data, including copies of the informed consent document, data collection instruments, surveys, or other relevant research materials.
 - a. At least once a year, the researcher shall provide the Chief, Office of Research and Evaluation, with a report of the progress of the research.
 - b. At least 12 working days before any report of findings is to be released, the researcher shall distribute one copy of the report to each of the following: the chairperson of the Bureau Research Review Board, the regional director, and the warden of each institution that provided data or assistance. The researcher shall include an abstract in the report of findings.
 - c. In any publication of results, the researcher shall acknowledge the Bureau's participation in the research project.

- d. The research shall expressly disclaim approval or endorsement of the published material as an expression of the policies or views of the Bureau.
 - e. Prior to submitting for publication the results of a research project conducted under this subpart, the researcher shall provide two copies of the material, for informational purposes only, to the Chief, Office of Research and Evaluation, Central Office, Bureau of Prisons
6. Other specific requirements of the Department of Justice (DOJ) Research Funded by the National Institute of Justice can be found in the “Additional Requirements for Department of Justice (DOJ) Research” section in the IRB’s HRP-318 - WORKSHEET - Additional Federal Agency Criteria.

Appendix A-7 ***Additional Requirements for Department of Education (ED) Research***

1. Each school at which the research is conducted must provide an assurance that they comply with the Family Educational Rights and Privacy Act (FERPA) and the Protection of Pupil Rights Amendment (PPRA).
2. Provide a copy of all surveys and instructional material used in the research. Upon request parents of children^{xvii} involved in the research^{xviii} must be able to inspect these materials.
3. The school in which the research is being conducted must have policies regarding the administration of physical examinations or screenings that the school may administer to students.
4. Other specific requirements of the Department of Education (ED) Research can be found in the “Additional Requirements for Department of Education (ED) Research” section in the IRB’s HRP-318 - WORKSHEET - Additional Federal Agency Criteria.

Appendix A-8 ***Additional Requirements for Environmental Protection Agency (EPA) Research***

1. Research conducted, supported, or intended to be submitted to EPA is subject to Environmental Protection Agency Regulations.
2. Intentional exposure of pregnant women or children to any substance is prohibited.
3. Observational research involving pregnant women and fetuses are subject to additional DHHS requirements for research involving pregnant women (45 CFR §46 Subpart B) and additional DHHS requirements for research involving children (45 CFR §46 Subpart D.)
4. Research involving children must meet category #1 or #2.
5. Other specific requirements of the Environmental Protection Agency (EPA) Research can be found in the “Additional Requirements for Environmental Protection Agency (EPA) Research and Research Intended to be Submitted to the Environmental Protection Agency” section in the IRB’s HRP-318 - WORKSHEET - Additional Federal Agency Criteria.

Appendix A-9 *Single IRB Studies*

1. That National Institutes of Health expects that all sites participating in multi-site studies involving non-exempt human subjects research funded by the NIH will use a single Institutional Review Board (sIRB) to conduct the ethical review required by the Department of Health and Human Services regulations for the Protection of Human Subjects at 45 CFR Part 46.
 - a. This policy applies to the domestic sites of NIH-funded multi-site studies where each site will conduct the same protocol involving non-exempt human subjects research, whether supported through grants, cooperative agreements, contracts, or the NIH Intramural Research Program. It does not apply to career development, research training or fellowship awards.
 - b. This policy applies to domestic awardees and participating domestic sites. Foreign sites participating in NIH-funded, multi-site studies will not be expected to follow this policy.
 - c. Exceptions to the NIH policy will be made where review by the proposed sIRB would be prohibited by a federal, tribal, or state law, regulation, or policy. Requests for exceptions that are not based on a legal, regulatory, or policy requirement will be considered if there is a compelling justification for the exception. The NIH will determine whether to grant an exception following an assessment of the need.
2. The Office for Human Research Protections expects that all sites located in the United States participating in cooperative research must rely upon approval by a single IRB for that portion of the research that is conducted in the United States. The reviewing IRB will be identified by the Federal department or agency supporting or conducting the research or proposed by the lead institution subject to the acceptance of the Federal department or agency supporting the research.

The following research is not subject to this provision:

- a. Cooperative research for which more than single IRB review is required by law (including tribal law passed by the official governing body of an American Indian or Alaska Native tribe); or
- b. Research for which any Federal department or agency supporting or conducting the research determines and documents that the use of a single IRB is not appropriate for the particular context.
- c. For research not subject to paragraph (b) of this section, an institution participating in a cooperative project may enter into a joint review arrangement, rely on the review of another IRB, or make similar arrangements for avoiding duplication of effort.

Appendix A-10 ***Additional Requirements for Research Subject to EU General Data Protection Regulations (GDPR)***

1. Human Research involving personal data about individuals located in (but not necessarily citizens of) European Union member states, Norway, Iceland, Liechtenstein, and Switzerland is subject to EU General Data Protection Regulations.
2. For all prospective Human Research subject to EU GDPR, contact institutional legal counsel or your institution's Data Protection Officer to ensure that the following elements of the research are consistent with institutional policies and interpretations of EU GDPR:
 - a. Any applicable study design elements related to data security measures.
 - b. Any applicable procedures related to the rights to access, rectification, and erasure of data.
 - c. Procedures related to broad/unspecified future use consent for the storage, maintenance, and secondary research use of identifiable private information or identifiable biospecimens.
3. Where FDA or DHHS regulations apply in addition to EU GDPR regulations, ensure that procedures related to withdrawal from the research, as well as procedures for managing data and biospecimens associated with the research remain consistent with Appendices A-1 and A-2 above.

Appendix A-11 ***Emergency/Disaster Preparedness Considerations for Investigators Conducting Human Research***

Investigators conducting human research should be aware of the following additional considerations associated with managing Human Research during an emergency/disaster scenario (e.g., extreme weather events, natural disasters, man-made disasters, infectious disease pandemics, etc.) related to investigators' ongoing interactions with research subjects and the institutional review board (IRB) in such cases.

During Emergency/Disaster Scenarios: Deciding Whether a Study-Specific Risk Mitigation Plan for Ongoing Research Is Needed

In general, investigators should develop a study-specific emergency/disaster risk mitigation plan for their research unless one of the following is true:

- Research does not involve in-person interaction with research subjects.
- Research can be conducted as written while adhering to additional institution-level and HRPP-level guidance and requirements regarding the emergency/disaster event.
- The research is externally sponsored, and the sponsor has developed a protocol-specific risk mitigation plan for the research.
- The research has been voluntarily placed on hold for recruitment and all research procedures (except for necessary follow-up procedures to be done consistently with additional institution-level and HRPP-level guidance and requirements regarding the emergency/disaster event).

Tools and Resources for Developing Study-Specific Emergency/Disaster Risk Mitigation Plans for Ongoing Research

Review “HRP-108 - FLOWCHART - Study-Specific Emergency-Disaster Risk Mitigation Planning” and “HRP-351 - WORKSHEET - Protocol-Specific Emergency-Disaster Risk Mitigation Planning” for general guidance on developing study-specific risk mitigation plans.

Voluntary Holds on Human Research Activities

Investigators may voluntarily elect to place all recruitment, enrollment and research procedures on temporary hold during emergency/disaster scenarios if doing so will better ensure the safety of research subjects and would not create any additional risks to the safety and welfare of research subjects. Such voluntary holds on research activity do not require IRB notification or review.

Submitting Study-Specific Emergency/Disaster Risk Mitigation Plans for IRB Review

If immediate modification of the research is necessary to eliminate an apparent immediate hazard to a subject, take action and notify the IRB within five business days following the standard pathway to submit reportable new information.

For all other study modifications made to ensure the ongoing safety of research subjects during emergency/disaster scenarios, submit a study amendment and all relevant new or modified study materials to the IRB.

Other Reportable New Information Considerations During Emergency/Disaster Scenarios

The IRB's list of reportable events includes two items for which additional clarification and guidance may be helpful during emergency/disaster scenarios:

- ***“Failure to follow the protocol due to the action or inaction of the investigator or research staff.”*** Emphasis on action or inaction of the investigator or research staff has been added because this requirement does not include action or inaction of the research subject. For example, study teams may notice an increase in the number of subjects who do not arrive for scheduled research visits under emergency/disaster circumstances. Failure of a research participant to appear for a scheduled research visit is not noncompliance due to action or inaction by the investigator or research staff, and therefore does not require reporting to the IRB.
- ***“Change to the protocol taken without prior IRB review to eliminate an apparent immediate hazard to a subject.”*** During emergency/disaster scenarios, there will be cases where there is sufficient time to receive IRB approval of any proposed modifications to previously approved research, and in such cases, investigators should follow standard IRB procedures for submitting modifications. However, there will be other cases where investigators must make more immediate changes to the protocol or investigational plan to minimize or eliminate immediate hazards or to protect the life and well-being of research participants. Such changes may be implemented without IRB approval, but are required to be reported to the IRB within five business days afterward in accordance with IRB policies and procedures for submitting reportable new information.

ⁱThis document satisfies AAHRPP element I.1.A, I.1.C-I.1.E, I-3, I.4.C, I.5.C, I.5.D, I.6.B, I.7.A-I.7.C, I-9, II.2.A, II.2.C, II.2.G, II.2.E-II.2.E.2, II.2.F-II.2.F.3, II.2.I, II.3.C-II.3.C.1, II.3.E, II.3.F, II.3.G, II.4.A, II.4.B, II.5.A, II.5.B, III.1.A, III.1.B, III.1.D, III.1.E, III.1.F, III.2.A, III.2.C, III.2.D

ⁱⁱ <http://www.hhs.gov/ohrp/policy/subjectwithdrawal.html>

ⁱⁱⁱ <http://www.fda.gov/downloads/RegulatoryInformation/Guidances/UCM126489.pdf>

^{iv} <http://www.accessdata.fda.gov/SCRIPTS/cdrh/cfdocs/cfcr/CFRSearch.cfm?fr=312.7>

^v <http://www.accessdata.fda.gov/SCRIPTS/cdrh/cfdocs/cfcr/CFRSearch.cfm?fr=312.60>

^{vi} <http://www.accessdata.fda.gov/SCRIPTS/cdrh/cfdocs/cfcr/CFRSearch.cfm?fr=312.61>

^{vii} <http://www.accessdata.fda.gov/SCRIPTS/cdrh/cfdocs/cfcr/CFRSearch.cfm?fr=312.62>

^{viii} <http://www.accessdata.fda.gov/SCRIPTS/cdrh/cfdocs/cfcr/CFRSearch.cfm?fr=312.64>

^{ix} <http://www.accessdata.fda.gov/SCRIPTS/cdrh/cfdocs/cfcr/CFRSearch.cfm?fr=312.66>

^x <http://www.accessdata.fda.gov/SCRIPTS/cdrh/cfdocs/cfcr/CFRSearch.cfm?fr=312.68>

^{xi} <http://www.accessdata.fda.gov/SCRIPTS/cdrh/cfdocs/cfcr/CFRSearch.cfm?fr=312.69>

^{xii} <http://www.accessdata.fda.gov/SCRIPTS/cdrh/cfdocs/cfcr/CFRSearch.cfm?fr=812.100>

^{xiii} <http://www.accessdata.fda.gov/SCRIPTS/cdrh/cfdocs/cfcr/CFRSearch.cfm?fr=812.110>

^{xiv} <http://www.accessdata.fda.gov/SCRIPTS/cdrh/cfdocs/cfcr/CFRSearch.cfm?fr=812.140>

^{xv} <http://www.accessdata.fda.gov/SCRIPTS/cdrh/cfdocs/cfcr/CFRSearch.cfm?fr=812.145>

^{xvi} <http://www.accessdata.fda.gov/SCRIPTS/cdrh/cfdocs/cfcr/CFRSearch.cfm?fr=812.150>

^{xvii} Children are persons enrolled in research not above the elementary or secondary education level, who have not reached the age or majority as determined under state law.

^{xviii} Research or experimentation program or project means any program or project in any research that is designed to explore or develop new or unproven teaching methods or techniques.