

ARGUS IRB

ARGUS INDEPENDENT REVIEW BOARD
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**All SAE's that occur at your site must be submitted within
3 business days of the Investigator's knowledge of the event.
In the event of death, report immediately.**

ONCE THIS FORM IS COMPLETED IN ITS ENTIRETY, PLEASE FAX TO (520) 298-7494

Date:		IRB#:		Protocol:	
Sponsor:			PI Name:		
Name of Drug or Device:					
Company Name:					
Address:				City:	
State:	Zip:	Contact Name:			
Phone #:			Fax #:		

Subject Information

<u>Subject Initials/ ID #:</u> _____		<u>Age:</u> _____	<u>Sex:</u> <input type="checkbox"/> M <input type="checkbox"/> F
<u>Report Type:</u> <input type="checkbox"/> Initial <input type="checkbox"/> Follow Up	<u>Date of Onset:</u> (MM/DD/YYYY)	<u>Date SAE Reported to Site:</u> (MM/DD/YYYY)	
Please describe the SAE: (Note: If you need additional space, please provide an additional sheet):			
Please describe the relationship (if any) to the study medication or device and/or the protocol design:			
Prepared by: _____		Date: _____	
Investigator Signature: _____		Date: _____	