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

Subject Initials/ ID #:_____	**Age:_____**	**Sex:** ☐ **M** ☐ **F**
Report Type: ☐ **Initial** ☐ **Follow Up**	**Date of Onset:** **(MM/DD/YYYY)**	**Date SAE Reported to Site:** **(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: