



CHINESE GENERAL HOSPITAL AND MEDICAL CENTER
DEPARTMENT OF MEDICAL EDUCATION AND RESEARCH
RESEARCH ETHICS REVIEW BOARD (RERB)



PROGRESS REPORT (FORM 20)

CGHMC RERB Protocol No.	Sponsor Protocol No.
Protocol Title	
Investigator: (Name and Signature)	Approval Date: (dd/mm/yyyy)
Annual Progress Report: <i>(Please indicate inclusive period):</i> Total number of screened subjects: Total number of randomized subjects: Total number of withdrawn patients: Total number of SAEs: Total number of lost to follow up: Total number of completed subjects:	
Submitted by:	Date Submitted: (dd/mm/yyyy)

To be filled up by RERB

Date Received:	Received by: (Printed Name/Signature)	
Primary Reviewers/Signature:		Date
Recommendations <input type="checkbox"/> Approved <input type="checkbox"/> Request further information <input type="checkbox"/> Suspend or terminate the study <input type="checkbox"/> Others: _____		Type of review: <input type="checkbox"/> Expedited review <input type="checkbox"/> Full board review Date of meeting: _____
RERB Final Decision:		
Certified by: Name of CGHMC RERB Chair	Signature	Date



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CONTINUING REVIEW APPLICATION FORM

CGHMC RERB Protocol No.	Sponsor Protocol No.
Protocol Title	
Investigator	Approval Date: (dd/mm/yyyy)
<p>ACTION REQUESTED:</p> <p><input type="checkbox"/> Renew – New participant accrual to continue</p> <p><input type="checkbox"/> Renew – Enrolled participant follow up only</p> <p><input type="checkbox"/> Terminate – Protocol discontinued</p>	
<p>Any amendment since last review? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(Discuss briefly)</p>	
<p>Any change in participant population recruitment or selection criteria since the last review? (Explain the changes if any) <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Any change in the Informed Consent process or documentation since the last review? (Please explain, if yes.) <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
<p>Is there any new information in recent literature or similar research that may change the risk/ benefit ratio for participants in this study? (Discuss and attach a narrative.) <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	



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<p>Any unexpected complication or side effect noted since the last review? (Discuss and attach a narrative.) <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Did any participant withdraw from this study since the last approval? (Reasons for withdrawal) <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Any new investigator that has been added to or removed from the research team since the last review? (Please identify them and submit the CVs of new investigators.) <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
<p>Are there any new collaborating sites that have been added or deleted since the last review? Please identify the sites and note the addition or deletion.</p>
<p>Summary of protocol participants:</p> <ul style="list-style-type: none"><input type="checkbox"/> Reached the target number of participants approved by CGHMC RERB<input type="checkbox"/> New participants recruited/enrolled since last review<input type="checkbox"/> Total participants screened since protocol began<input type="checkbox"/> Total participants enrolled and ongoing since the last review<input type="checkbox"/> Total number of SAEs since the last review<input type="checkbox"/> Total number of participants withdrawn or terminated
<p>ACCRUAL EXCLUSIONS</p> <ul style="list-style-type: none"><input type="checkbox"/> None<input type="checkbox"/> Male<input type="checkbox"/> Female<input type="checkbox"/> Others (Specify) _____



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Impaired participants <input type="checkbox"/> None <input type="checkbox"/> Physically <input type="checkbox"/> Cognitively <input type="checkbox"/> Both
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To be filled up by RERB

Date Received:	Received by: (Printed Name/Signature)	
Primary Reviewers/Signature:		Date:
Recommendations <input type="checkbox"/> Approved <input type="checkbox"/> Request amendment to the protocol or the consent form <input type="checkbox"/> Request further information <input type="checkbox"/> Suspend or terminate the study <input type="checkbox"/> Others: _____	Type of review: <input type="checkbox"/> Expedited review <input type="checkbox"/> Full board review Date of meeting: _____	
RERB Final Decision:		
Certified by: Name of CGHMC RERB Chair	Signature	Date