SOUTHLAKE
REGIONAL HEALTH CENTRE

596 Davis Drive
Newmarket, Ontario
L3Y 2P9

Tel. (905) 895-4521, ext. 2763
Fax. (905) 952-3068
Website: www.southlakeregional.org
REBsubmissions@southlakeregional.org

Research Department

Research Ethics Board: Study Closure Notice

Date of this submission: _____

A. Study Information

A.1. Study Title:

A.2 SRHC REB Number:

A.3 Name of local Qualified Investigator:

A.4 Name of Trial Coordinator: ❑ N/A

B. Approval History

B.1 Date of original SRHC REB Approval: _____

B.2 Type of Approval: ❑ Full Board ❑ Delegated Review

B.3 Current expiry date: _____

C. Enrollment History

C.1 Total Number of Participants consented: _____.

C.2 Total Number of screen failures: _____.

C.3 Total Number of Participants withdrawn or lost to follow-up: _____.

C.4 Total Number of Participants deceased: _____.

C.5 Total Number of Participants who have completed study: _____.

C.6 Total Number of Participants who are still enrolled on study follow-up: _____.
(The number in box C.1 should equal the total of boxes C.2 through C.6)

C.7 Plan to address Participants still enrolled: *(of premature study closure)* ❑ N/A

_____

C.8 If this study involved only record/data review or specimen review, the total number of records/specimens reviewed: ❑ N/A

_____

D. Reason for Closure (check the most appropriate)

D.1 ❑ Study Endpoint reached

SL0770_09 "Research Department" Review (12/17)

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D.2 ❑ Sponsor Initiated *(give reason or append letter)*

D.3 ❑ Local Qualified Investigator Initiated *(give reason)*

E. REB Reports

E.1 Have all Serious Unanticipated Events occuring at SRHC been reported to the SRHC REB: *(per SHRC policy)*

❑ Yes ❑ No ❑ N/A **If no, please explain:**

E.2 Have all reportable deviations at the SRHC site been reported to the SRHC REB: *(per SHRC policy)*

❑ Yes ❑ No ❑ N/A **If no, please explain:**

F. Presentation/Publications

F.1 Have there been any presentations/publications from the local Qualified Investigator/team related to this study?

❑ Yes ❑ No ❑ N/A _____

F.2 Are presentations/publications planned by local Qualified Investigator/team in the future?

❑ Yes ❑ No _____

G. Attestation

I certify that the information provided in this form is correct to the best of my knowledge.

My signature below confirms the accuracy of this report.

Name of Local Qualified Investigator: _____

Signature of Local Qualified Investigator: _____ **Date:** _____

Name of person completing this form: _____

Signature of person completing this form: _____ **Date:** _____

RETURN THIS COMPLETED FORM TO THE RESEARCH OFFICE:

Southlake Regional Health Centre Medical Arts Building, 596 Davis Drive, Suite 512 Newmarket, Ontario L3Y 2P9
Phone: 905-895-4521 ext. 2763 Fax: 905-952-3068 Email: REBsubmissions@southlakeregional.org

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