



WAIVER / DEFERENCE OF REVIEW FORM

Study Title:

Sponsor:

Protocol No.:

CRO/SMO:

Principal Investigator Name:

Institution/Hospital Name:

Address:

Designated Contact Person: Title:

Telephone:

The above referenced Institution/Hospital **does not** have a board, group, or committee to review this protocol and all related materials, therefore the review, monitoring, and follow-up of this protocol and all related materials, will be conducted by ASPIRE IRB.

Principal Investigator/or Designee Signature: _____ Date: _____

The above referenced Institution/Hospital has an IRB which hereby defers the right to review to ASPIRE IRB **and will not duplicate the review.** The review, monitoring, and follow-up of this protocol and all related materials will be conducted by ASPIRE IRB.

IRB Chair Printed Name: _____

IRB Chair Signature: _____ Date: _____

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