Faculty Resources

8. UAMS Policies on Research and Grant Awards

Authority of the Institutional Review Board (Executive Memorandum)

Compensation for Employee Participation in Research (Admin Policy 4.2.13)

Distribution of Royalties from Patents, Copyrights and Licenses (Admin Policy 12.1.05)

Ethical Standards in Research and Procedure (Admin Policy 12.1.04)

Grants and Contracts Proposal/Award Procedures (Admin Policy 12.1.01)

Mandatory Education Policy for Investigators/Study Personnel Participating in Human Subject Research Projects (Admin Policy 12.1.06)

Responsibilities of the Central Administration (Admin Policy 12.1.02)

Responsibilities of the Principal Investigators (Admin Policy 12.1.03)

The complete UAMS Administrative Guide may be found at http://uams.edu/AdminGuide/index.html

Research Administration and Support Units

A number of units are available to UAMS faculty involved in research, including those located at the VA and Arkansas Children’s Hospital, including:

Arkansas Children’s Hospital Research Institute

Automated Research Information Administrator (ARIA)

General Clinical Research Center

Office of Clinical Trials

Office of Grants & Scientific Publications

Office of Research and Sponsored Programs

- Institutional Review Board (Human Subject review)
- Investigators’ Handbook

Office of Research Compliance

UAMS Patient and Copyright Disclosure Committee

http://www.uams.edu/academicaffairs/facultyresources/research.asp

12/6/2005
Executive Memorandum

DATE: 8/13/2004
REVISION:

SECTION: ACADEMIC AFFAIRS RESEARCH
AREA: ADMINISTRATION
SUBJECT: Authority of the Institutional Review Board (IRB)

Policy

The IRB has the authority to review all research conducted by UAMS faculty, staff and students to ensure that human subjects involved in research activities are given the broadest protections provided by the canons of ethical research, applicable federal, state, and local laws and regulations, institutional guidelines, and common practice guidelines as set forth by the International Committee on Harmonisation.

The IRB will function as an independent and autonomous deliberative body within the University, free of undue influence on its judgments regarding the appropriateness of research and protections afforded human participants. Organizationally, the IRB will operate under the auspices of a Human Research Subjects Protection Program that provides for management by the campus' senior science officer, the Vice Chancellor for Academic Affairs/Research Administration (the VCAA), who in turn reports directly to the campus' chief executive, the Chancellor.

The IRB has the right to constitute itself with regard to structure, governance, and operating principles (within its management framework), that it determines most effective in pursuing its mission to protect human research subjects under its purview, whether at UAMS or other organizations for whom the UAMS IRB conducts research review.

Specific authority is given to the Institutional Review Board (IRB) to:

1. Approve, disapprove, or require modifications of research activities
2. Require progress reports and safety information from the investigators and oversee the conduct of the studies
3. Suspend or terminate approval of an ongoing study.
4. Suspend or terminate an investigator's privileges to conduct research.
5. Reopen terminated/closed protocols and reinstate investigator's privileges.
6. Function as the Institution's privacy board for research.
In its review of human subject research, the IRS has jurisdiction over all aspects of the research including, but not limited to:

1. Methods of identifying potential subjects
2. Methods proposed for contacting potential subjects
3. Materials to recruit subjects and proposed compensation
4. Pilot studies
5. Proposals to use or provide stored blood, tissues, or confidential data
6. Surveys and questionnaires
7. The informed consent process and forms
8. The protocol and summary of the research
9. Evaluation of risks and benefits to subjects
10. Unanticipated problems involving risk to subjects
11. Proposed changes to the research
12. Continuing reviews
13. Use of investigational drugs and devices in emergencies
14. Humanitarian use of drugs and devices
15. Eligibility for exemption or expedited review

In order to approve research, the IRS shall determine that a minimum of all of the following requirements are satisfied

1. Risks to subjects are minimized
2. Risks to subjects are reasonable in relation to anticipated benefits,
3. Selection of subjects is equitable.
4. Informed consent will be sought from each prospective subject or the subject's legally authorized representative.
5. Informed consent will be appropriately documented..
6. The research plan makes adequate provision for monitoring the data collected, when necessary.
7. Provisions to protect the privacy of subjects and to maintain the confidentiality of patient data are adequate, when necessary.

Undue Influence

Individual IRS members, whether employed by the institution or an affiliate or lay members, have both the obligation and right to report any undue pressure upon them to make decisions at the convened IRS meetings that would favor an individual investigator or the institution over the welfare and safety of the research subject. The manner in which the IRS member chooses to report such undue pressure can take various pathways, depending upon the member's perceived need for anonymity. Reports can be made orally or written (with or without identity). Options of reporting are as follows:

IRS Chairman
IRS Administrator
Director of Research Administration
Regardless of the pathway chosen by the IRB member, the Vice Chancellor for Academic Affairs and Sponsored Research at UAMS will be informed by the other individuals and will be responsible for the official investigation of the reported undue pressure. In a timely manner, the Vice Chancellor for Academic Affairs and Sponsored Research at UAMS will inform the IRB member of the investigation findings and actions taken to alleviate the undue pressure.

EXAMPLES:

The IRB member is an Assistant Professor in an academic department and is due for consideration of promotion and tenure. A full Professor in the department who is on the Promotion and Tenure Committee has a grant that has received a favorable score for funding but the IRB has found problems with the protocol and consent as written that has resulted in what the full Professor considers needless delays. The full Professor goes to the IRB member and seeks to have him disclose proceedings of the convened IRB at which his protocol was discussed and voted on. Particularly, the full Professor desires to obtain names of IRB Committee members who reviewed and/or spoke up against his protocol or voted in an unfavorable manner so he can contact them to express his displeasure and perhaps even to make waves with the Dean. Because the IRB member knows that all proceedings of the convened meetings are confidential, he must refuse the full Professor’s request and report the incident.

A Departmental Chairman requests that an IRB member, who is a senior faculty member in their department come by for a visit. The Chairman expresses concern that the IRB committee has been making too many unfavorable decisions regarding protocols submitted by persons in the department. The IRB member is requested to divulge information concerning how the convened IRB Committee makes decisions and how the process could be made more favorable to applications from the department. Specific protocols are not discussed but it is obvious that the Chairman is seeking to "take names and kick butt" to influence decisions made by the IRB. The IRB member knowing of the confidential nature of all IRB proceedings, respectfully suggests that the Chairman should schedule a meeting with the IRB Chairman and the Vice Chancellor for Academic Affairs and Sponsored Research at UAMS to discuss how the IRB could better educate researchers in Federal regulations and the need for more guidance in preparing protocol submissions for IRB consideration.

A lay member of the IRB, who is not affiliated with the institution, is contacted by a reporter for the local newspaper. There has been an unexpected death in a research study and the reporter is investigating the death following prompting by the family of the deceased. The reporter has found the name of the lay member from the IRB web site and believes that since she is not affiliated with the institution information might be available that would not be forthcoming from other IRB members. Particularly, the reporter is interested in information concerning how the IRB approved the study and information concerning how the death was reported to the Committee. The lay member is courteous to the reporter but lets him know that all proceedings of the IRB Committee are confidential and that any release of information will have to come from the Vice Chancellor for Academic Affairs and Sponsored Research at UAMS. The lay member then reports the incident.
UAMS ADMINISTRATIVE GUIDE

NUMBER: 4.2.13
DATE: 09/15/2004
REVISION:

SECTION: HUMAN RESOURCES
AREA: COMPENSATION
SUBJECT: COMPENSATION FOR EMPLOYEE PARTICIPATION IN RESEARCH

POLICY

UAMS recognizes that UAMS employees can contribute to the work of the University by participating in research projects as human subjects. In this regard, such activities are beyond the scope of any job description, and the participating employee may be paid above his normal salary for such activities. However, the amount must be included in total employee compensation for tax purposes. These procedures will establish uniform guidelines for such payments.

PROCEDURE

1. Employees (classified and non-classified) may be paid additional amounts for their voluntary participation as subjects of UAMS research in amounts determined by the Principal Investigator. The amount of compensation, when added to regular salary, may not exceed the Line Item Maximum salary established for the regular position of the participating employee.

2. The project must be one which conforms to Administrative Guide section 12.1, Research Administration, and is formally approved by the UAMS Human Research Advisory Committee (HRAC). See http://www.uams.edu/ora/irb/index.htm

3. If time off is taken for this participation, the employee must coordinate this with the supervisor or department head: vacation/annual leave may be charged to the employee.

4. Following the completion of tasks or services by the employee, the Principal Investigator or his business manager will submit a request for payment: Please click here and use this template for payment.

5. When approved, the request will be forwarded to Finance/Payroll for payment.

6. All payments to employees will be paid through normal payroll process and will be subject to all taxes and mandatory withholdings. Such payments are not eligible for retirement contribution or employer matching.

REFERENCE

1 UAMS Policy 12.01.03
The purpose of this policy is to notify colleges and researchers within the University of Arkansas for Medical Sciences (UAMS) of the procedures that are followed when allocating the costs and the distribution of income resulting from a successful patent, copyright or license.

It is the policy of the University of Arkansas to acquire and retain legal title to all inventions created by any person or persons to whom this policy is applicable. This policy is established in furtherance of the commitment of the University to the widest possible distribution of the benefits of University Research, the protection of Inventions resulting from such research, and the development of Inventions for the public good.

This policy shall apply to all persons employed, compensated, or appointed by the University and to anyone using facilities owned, operated, or controlled by the University. It shall also apply to all Inventions financed, in whole or in part, from funds under the control of UAMS.

PROCEDURE

1. All persons to whom this policy is applicable shall petition the UAMS Patent and Copyright Committee of their intent to seek a patent or copyright. The Patent and Copyright Committee will decide whether to seek the patent, copyright or license; release the petitioner; or take no action.
2. The UAMS Patent and Copyright Committee will notify the General Counsel of the University of Arkansas System if they wish to seek a patent or copyright. The General Counsel’s Office will obtain Counsel on behalf on the University and the petitioner. The legal costs related to the application of the patent, copyright, or license are charged back to UAMS.
3. Once a patent, copyright, or license is obtained, sale of the patent, copyright, or license is negotiated by the UAMS Office of Research Administration and the General Counsel of the University of Arkansas System together with the appropriate college or the researcher.
4. When a contract is approved and payment is received by the Controller’s Office it will be deposited into the Patent, Copyright and License Control Account. The Controller’s office will make distribution within 30 days of deposit of the royalty payment in the UAMS Treasurer’s Office. The Controller’s Office will reduce the payment amount by the actual costs for patenting, licensing, and the protection of patent rights and copyrights. If the cost of obtaining the patent, copyright, or license exceed 20% of the initial payment, only 20% will be charged against the initial payment. The balance of the costs will be charged against succeeding payments, with a maximum of 20% of any single payment being charged, until all costs are covered. The net distribution will be as follows:

For net royalty proceeds for income up to $200,000:
- For Income over $200,000
  - 50% to the Inventor(s)
  - 35% to Inventor(s)
  - 5% to U of A System
  - 42% to Appropriate College
  - 18% to Chancellor & Processing Reserve

For example, if a patent is sold for $100,000, and legal costs were $10,000, the net proceeds of $90,000 will be distributed as follows:

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross Receipt</td>
<td>$100,000</td>
</tr>
<tr>
<td>Less: Direct Costs</td>
<td>$10,000</td>
</tr>
<tr>
<td>Available for Distribution</td>
<td>$90,000</td>
</tr>
<tr>
<td>Distribute to Inventor (50%)</td>
<td>$45,000</td>
</tr>
</tbody>
</table>
If a patent sold for $300,000, and legal costs were $10,000 the net proceeds of $290,000 will be distributed as follows:

<table>
<thead>
<tr>
<th>Distribution</th>
<th>Amount</th>
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</thead>
<tbody>
<tr>
<td>Gross Receipt</td>
<td>$300,000</td>
</tr>
<tr>
<td>Less: Direct Costs</td>
<td>10,000</td>
</tr>
<tr>
<td>Available for Distribution</td>
<td>290,000</td>
</tr>
</tbody>
</table>

**First $200,000 Additional $90,000**

- **Distribute to Inventor (50%)** 100,000 (35%) 31,500
- **Distribute to UA System (5%)** 10,000 (5%) 4,500
- **Distribute to Appropriate College (31.5%)** 63,000 (42%) 37,800
- **Distribute to Chancellor (13.5%)** 27,000 (18%) 16,200

5. Contact the Office of Research Administration for assistance and additional information.

1. UofA Board Policy 210.1 - Patent and Copyright Policy
The purpose of this policy is to maintain the research credibility of the faculty, staff, and the University of Arkansas for Medical Sciences campus so that there will be public confidence in scientific research and any injury to the public interest will be avoided. It is recognized that, as is the case with all human endeavors, honest mistakes will occur in the conduct of scientific research. Therefore, investigators who inadvertently make errors in either the planning, execution or interpretation of scientific research shall not be considered in violation of the policy contained within this document.

It is the policy of the University of Arkansas for Medical Sciences (UAMS) that all scientific research engaged in by faculty and staff of this campus must be conducted, and the results reported, with integrity. Indicated research must have actually been performed. Data must be verified and academic honesty must prevail. Research findings must be fairly attributed as to their authors. Research results are to be documented and comply with federal requirements that uniquely relate to the conduct of that research. The following conduct, which this policy addresses, constitutes scientific misconduct and includes, but is not limited to:

a. Knowingly misrepresenting or falsifying research data.

b. Intentionally concealing actual facts material to research results reported, or falsely representing actual facts discovered which are material to research results reported.

c. Filing research reports and/or publishing research findings without having done the research indicated.

d. Falsely claiming to be the author of research which was performed by others.

e. Deceitfully reporting research of others as one’s own and/or plagiarism involving the work of others.

f. Material failure to comply with federal requirements that uniquely relate to the conduct of research. This would include, but not be limited to, failure to comply with federal requirements for protection of human subjects or for ensuring the welfare of laboratory animals.

Research at UAMS is expected to be conducted with full regard for the academic freedom of those so involved, and with the responsibility for insuring that the intentional perversion or suppression of truth does not compromise scientific research in the medical sciences. Scientific misconduct undermines the methods and purposes of those scientists using acknowledged research methods.

Principal investigators and laboratory directors are ultimately responsible for the supervision and verification of research programs and personnel in their laboratories. This responsibility includes the maintenance of accurate and reliable records and data, the preparation of quality research papers, and the assurance that the authors of papers have actually contributed to the research efforts reported.

A charge of scientific misconduct is a most serious charge. For that reason, the Vice Chancellor, the review committees and all others involved in the inquiry or investigation shall take whatever actions are necessary to protect, to the maximum extent possible, the privacy of those who, in good faith, report apparent misconduct. In addition, the Vice Chancellor, the review committees and all others involved in the inquiry shall afford the affected individual(s) confidential treatment to the maximum extent possible. Further, should the charge not be sustained, formal and extensive efforts are to be made so that the reputation of the person against whom the charge was made shall not be impaired. Charges made maliciously and in bad faith, after so found, shall lead to employee disciplinary action.

PROCEDURE (GENERAL)

1. Initial reports that scientific misconduct may have occurred are to be made to the Vice Chancellor for Academic Affairs, hereafter referred to as the Vice Chancellor. The Vice Chancellor must then inform the Dean(s) of the College(s) of the person making the initial report and of the person so charged. In certain instances, others, as required by law, regulation or contract, may also be notified at this
time. See UAMS Policy 12.1.04, Procedure 21, for Federal Regulations specifically relating to Federally funded projects.

**PROCEDURE (INITIAL INQUIRY)**

2. The initial inquiry of the charge that scientific misconduct may have occurred must be by an internal review panel of full time UAMS faculty members, termed the Inquiry Committee. This inquiry must be completed within 60 calendar days of its initiation, i.e., from the time of receipt of the initial allegation by the Vice Chancellor, unless circumstances clearly warrant a longer period. If the inquiry takes longer than 60 days to complete, the record of the inquiry must include documentation of the reasons for exceeding the 60 day period.

3. The Vice Chancellor, in consultation with the Dean of the person so charged, must prepare a list of potential committee members from the UAMS faculty roster, making every effort in the selection process to form an Inquiry Committee with the appropriate scientific expertise. This list must be presented to the person so charged and he/she may request that any potential member not be impanelled by submitting to the Vice Chancellor a written explanation of why the person(s) should not serve on the committee. The Vice Chancellor, in consultation with the Dean of the person so charged, must decide on the validity of the challenge to any potential committee member, and choose six members to serve as the Inquiry Committee. Once formed, the Inquiry Committee must elect one of its members to assume the role of chairman.

4. The members of the Inquiry Committee must have no real or apparent conflict of interest and will be asked to sign a statement to this effect. Any relationship with the involved parties must be disclosed to those involved in the inquiry. Any member of the Inquiry Committee with a conflict of interest must be replaced with a member selected by the Vice Chancellor.

5. The Vice Chancellor is to be present in a non-voting capacity at all Inquiry Committee meetings to provide procedural advice to the committee members. At his/her discretion, the Dean or his/her designee of the College of the charged person may also be present in a non-voting capacity. Only the person giving testimony to the committee and the above noted exceptions may be present in any meeting. Legal counsel may not be present during meeting of the Inquiry Committee.

6. The Inquiry Committee shall make an inquiry of the evidence which may include interviewing persons with relevant information. An inquiry means information gathering and initial fact finding to determine whether an allegation or apparent instance of misconduct warrants an investigation. Once the inquiry is initiated, the charged person is obligated to cooperate by providing material necessary for the proceedings of the Inquiry Committee. Failure to do so may result in immediate Investigative Review (See UAMS Policy 12.1.04, Procedures 10-18) or other institutional sanctions.

7. At the conclusion of the inquiry, the Inquiry Committee must decide, by a majority vote, whether an investigation into the allegation of the scientific misconduct is warranted. The committee must prepare a written report that states what evidence was reviewed, summarizes relevant interviews, and includes the conclusions of the inquiry. This report must provide sufficiently detailed documentation of the inquiry to permit a later assessment of the reasons for determining that an investigation was not warranted, if necessary. This inquiry report must be forwarded to the Vice Chancellor, Dean of the person charged, and the individual(s) who made the allegation. The person charged with scientific misconduct may comment on the report, and his/her comments will be made part of the record.

8. All records must be maintained in a secure manner in the Office of the Vice Chancellor for a period of at least three years after the termination of the inquiry, and must, upon request, be provided to authorized personnel as required by law, regulation or contract.

9. If the Inquiry Committee finds that an investigation into the allegation of scientific misconduct is not warranted, the Vice Chancellor, and all other persons involved, must, to the maximum extent possible, take steps to minimize the damage to reputations which may result from inaccurate reports.

**PROCEDURE (INVESTIGATIVE REVIEW)**

10. If the Inquiry Committee finds that an investigation is warranted, the Vice Chancellor must initiate the investigation by impaneling an Investigative Committee within 30 days of receiving the report of the Inquiry Committee. This investigation should ordinarily be completed within 120 days of its initiation. However, if this deadline cannot be met and the project(s) involve federally-funded research, then a written request for an extension must be submitted to the appropriate office as required by federal regulations.

11. The Vice Chancellor, in consultation with the Dean of the person so charged, must prepare a list of potential committee members, making every effort in the selection process to form an Investigative Committee with the appropriate scientific expertise. This list must be presented to the person so charged and he/she may request that any potential member not be impanelled by submitting to the Vice Chancellor a written explanation of why the person(s) should not serve on the Committee. The Vice Chancellor, in consultation with the Dean, will then decide on the validity of the challenge to any potential committee member.

12. The Vice Chancellor must appoint an Investigative Committee. It is to consist of six members, at least four of whom are full-time faculty members of UAMS at the rank of associate or full professor. Up to two scientists who are not employees of the University of Arkansas for Medical Sciences, each of whom must be personally qualified to judge the scientific nature of the research work, may also be appointed to the Committee. Once formed, the Investigative Committee must elect one of its members to assume the role of chairman.

13. The members of the Investigative Committee must have no real or apparent conflict of interest and will be asked to sign a statement to this effect. Any relationship with the involved parties must be disclosed to those involved in the investigation. Any member of the Investigative Committee with a conflict of interest must be replaced with a member selected by the Vice Chancellor.

14. The Vice Chancellor is to be present in a non-voting capacity at all committee meetings to provide procedural advice to the committee members. At his/her discretion, the Dean or his/her designee of the college of the charged person may also be present in a non-voting role.
capacity. Legal counsel or another advisor may be present during meetings of the Investigative Committee in which the person so charged is interviewed to provide advice but may not address the committee. Only the person giving testimony to the committee, and the above noted exceptions, may be present in any committee meeting.

15. The Investigative Committee shall investigate fully to determine if scientific misconduct, as defined by this policy, has occurred. In doing so, it may utilize any files developed by the Inquiry Committee and may review any additional evidence deemed relevant through procedures adopted by the panel. The Committee must secure necessary and appropriate expertise to carry out a thorough and authoritative evaluation of the relevant evidence. The investigation normally will include examination of all documentation, including, but not necessarily limited to, relevant research data and proposals, publications, correspondence, and memoranda of telephone calls. Whenever possible, interviews should be conducted of all individuals involved either in making the allegation or against whom the allegation is made, as well as other individuals who might have information regarding key aspects of the allegations. Complete summaries of these interviews should be prepared, provided to the interviewed party for comment or revision, and included as part of the investigatory file. All involved parties are obligated to cooperate fully with the proceedings of the Investigative Committee. Funding agencies must be kept appraised of developments during the course of the investigation, as required by law, regulation or contract.

16. The Investigative Committee must determine, by a majority vote of its members, whether scientific misconduct has been proven by a preponderance of the evidence, and if so, must recommend sanctions.

17. The Investigative Committee must provide a written report of its findings to the Vice Chancellor, the Dean(s) of the person charged and the person making the charge, the person making the charge, the person(s) so charged and others to the extent required by law, regulation or contract. The report shall include the documentation which supports the committee's findings. Only the Vice Chancellor may release a copy of this personnel determination to third parties. Reports from the Investigative Committee must, otherwise, remain confidential and must be secured in the Office of the Vice Chancellor. All records must be maintained for a period of at least three years after the termination of the investigation.

18. If the Investigative Committee does not find that scientific misconduct has occurred, the Vice Chancellor must, to the maximum extent possible, take steps to minimize the damage to reputations which may result from inaccurate reports.

PROCEDURE (APPEALS PROCESS)

19. The decision of the Investigative Committee may be appealed. Appeals are made to the Chancellor of UAMS and must be filed within seven days of the Investigative Committee's decision. Any such appeal will be limited to the evidence presented during the investigative review and the grounds for appeal are limited to failure of the Investigative Committee to follow appropriate procedures or that an arbitrary decision was made. New evidence contained within the appeal may warrant a reopening of the investigation. The decision of the Chancellor is final.

PROCEDURE (SANCTIONS)

20. If the Investigative Committee finds that scientific misconduct has occurred, the Vice Chancellor and the Dean of the person so charged, with due consideration of the recommendation of the Investigative Committee, must recommend to the Chancellor sanctions to be imposed. The Chancellor must then impose sanctions in accordance with UAMS personnel policies after the conclusion of the appeals process.

PROCEDURE (FEDERAL POLICY)

21. The Vice Chancellor must notify the Office of Scientific Integrity (OSI), in accordance to Federal Policy (Federal Register 54:32450, 50.103d) when, on the basis of an initial inquiry, the institution determines that an investigation is warranted, or, prior to the decision to initiate an investigation,if any of the following conditions exist:

   a. There is an immediate health hazard involved.
   b. There is an immediate need to protect Federal funds or equipment
   c. There is an immediate need to protect the interests of the person(s) making the allegations or of the individual(s) who is the subject of the allegations as well as his/her co-investigators and associates, if any.
   d. It is probable that the alleged incident is going to be reported publicly.
   e. There is a reasonable indication of possible criminal violation. In that instance, the Vice Chancellor must inform the OSI within 24 hours of obtaining that information.

REFERENCE

1 UAMS Policy 12.1.03
The Office of Research Administration (ORA) supports the sponsored research efforts of departments within the University of Arkansas for Medical Sciences. ORA concentrates the functions required to process research applications and to provide information and advice related to the University's sponsored research program. The ORA staff operate with the goal of detailing the administrative/accounting aspects of sponsored research while maintaining a necessary level of coordination between the activities of principal investigators and project directors and the rules and regulations under which the University operates. The ORA offers services in the areas of research administration, sponsored research funding source identification, proposal development, faculty research interest identification, research sponsor interface, contracts, and subcontracts.

PROCEDURE

1. The ORA serves as the central information and clearance office for matters of sponsored research or related administration issues. The ORA offers services such as; formatting and calculating proposal budgets, obtaining acceptance signatures for awards received, providing research administrative statistics, developing and producing research-related agreements and other sub-awards.

2. The staff of the ORA assist in identifying sources of potential funding for researchers and contacting potential sponsors for investigators.

3. The ORA staff is available to assist researchers in the grantsmanship process. The staff coordinates researchers’ interest with the extramural research requirements of sponsor agencies. An additional function of the ORA staff is making enquiries regarding funding needs of investigators and the status of their applications.

4. Specific instructions on developing and writing proposals may be found in Appendix J of the Research Administration Guide.

5. Contact the Office of Research Administration at extension 65502 for assistance and additional information.
The purpose of this policy is to define the Human Subject Protection educational requirements for investigators and key personnel involved in human subject research overseen by the University of Arkansas for Medical Sciences Institutional Review Board (UAMS IRB).

Recognizing the complexity of the federal, state, and campus policies and regulations created to adequately protect the rights of human subjects in research, UAMS has adopted the mandatory education program outlined below for all IRB members, Principal Investigators, and all key research staff having contact with human subjects, human subject data, or biological specimens. Key research staff may be defined as those persons whose responsibilities may include, but are not limited to, day-to-day protocol decision-making related to the study conduct; subject recruitment, selection and eligibility; clarification of the complexities of the protocol to the subject and others; collecting subject information; and entering data.

Recertification is required every two years after completion of the initial educational program requirement.

Accepted Educational Programs

Completion of one of the following educational programs will meet mandatory UAMS requirements for investigators and key personnel involved in human subject research.

1. Successful completion of one of the UAMS web-based tutorial programs on Human Subject Protection AND the HIPAA training course at http://www.uams.edu/orc/. Researchers should complete one of the Human Subject Protection Training Programs appropriate to their research discipline:
   - Biomedical Course on Human Subject Protection Training

   OR

   - Behavioral and Social Science Course on Human Subject Protection Training

   The Biomedical Course is appropriate for persons whose research involves drugs, devices, and surgical/invasive procedures. The Behavioral and Social Science course is relevant to those disciplines and is not appropriate for investigators whose research involves drugs, devices or surgical/invasive procedures. Both courses integrate UAMS IRB requirements.

   In addition, the on-line HIPAA for Research Training Course is required of all researchers. The HIPAA course is a short overview of the researcher and key research personnel responsibilities for confidentiality, use and disclosure of Protected Health Information obtained during research. UAMS, CAVHS and ACH each have additional policies and procedures to follow regarding HIPAA.

   On-line courses are followed by exams and a record of successful completion is maintained by the Office of Research Compliance. The UAMS IRB will have access to these completion records. This course will be updated quarterly and, if regulatory changes dictate, more frequently by the Office of Research Compliance.

2. Attendance and successful completion of the seminar “Conduct of Human Subjects Studies” sponsored by UAMS and/or ACH will also fulfill the Human Subject Protections Training Requirement. This seminar is scheduled to be taught yearly and includes history, ethics, federal regulations, UAMS IRB procedures, and discussions pertinent to the group’s interests. There is an exam and certificates of training are distributed to attendees if a successful score (80%) is achieved. If an attendee does not achieve an 80% on the initial attempt, the online course and test must be taken and passed.

3. On a case-by-case basis, the UAMS IRB Director and the Office of Research Compliance Director will consider other programs with equivalent or better content to meet this requirement.
Persons should save a copy of printed certificates of completion upon finishing any course other than the UAMS on-line courses.

Who Must Comply With This Policy

The requirement of mandatory completion of the Human Subject Protection Training applies to the following individuals:

1. Investigators (including faculty, residents, and students) submitting a human subjects protocol to the IRB for review and approval.
2. Investigators and persons participating in human subject research, including faculty, residents, and students.
3. Faculty Supervisor of investigator submitting a human subject’s protocol to the IRB for review and approval (if the investigator is a student).
4. Persons responsible for, but not limited to, day-to-day protocol decision-making related to the study conduct; subject recruitment, selection and eligibility; clarification of the complexities of the protocol to the subject and others; collecting subject information; and entering data.
5. Research Coordinators, Research Nurses, and Research Assistants/Associates
6. Members of the UAMS IRB.

Deadline for Compliance

Effective January 31, 2004, all persons to whom this policy applies must have documentation of one of the acceptable courses listed above for Human Subject Protection. Mandatory HIPAA training for researchers was due 4/14/03. Persons without appropriate training may not conduct research after these deadlines.

Continuing Education

Recertification will be required every two years through one of the methods below:

- Re-completion of the web-based tutorial programs at http://www.uams.edu/orc/
- Re-attendance of the seminar “Conduct of Human Subject Studies”
- Other programs (e.g. Association of Clinical Research Professionals Seminar in Investigator Training) may be an acceptable alternative to the above courses. Please contact the Office of Research Compliance if this is chosen as an option.

Affiliate Institutions Requirements

Arkansas Children’s Hospital

ACH and ACHRI consider this policy as the mandatory base requirements for Human Subject Protection and HIPAA Training on its campus. ACHRI will work with the Office of Research Compliance Educator to enhance the on-line training courses to assure the protection of children in research. Additional courses required by ACH/ACHRI will be announced.

Central Arkansas Veteran Hospital (CAVHS)

In addition to the UAMS IRB requirements listed above, researchers at CAVHS may have additional educational requirements. The VA R & D Office should be consulted for these requirements.

For More Information

Questions concerning this policy should be directed to the UAMS Office of Research Compliance at (501) 526-6876.

Other Contact Numbers:
ACHRI: 501-364-3571
VA R & D: 501-257-4818
PURPOSE

The purpose of this policy is to inform departments within the University of Arkansas for Medical Sciences (UAMS) of the responsibilities held by Central Administration in regard to proposal procedures.

PROCEDURE

1. Central Administration will assist principal investigators/project directors by providing advice regarding potential funding agencies; facilitating communication with those agencies; assisting with the formation of an appropriate proposal budget; reviewing the completed proposal; providing advice regarding post-proposal submittal communication; and helping negotiate all budgetary matters.

2. Central Administration personnel or the Controller's Office will notify principal investigators/project directors of an award and provide appropriate information, account numbers (fund/center numbers), instructions, and copies of award material.

3. Central Administration will review award documents to ensure that their terms are in the best interests of principal investigators/project directors and UAMS; obtain the signature approval (UAMS acceptance) of the appropriate UAMS official for an award; and ensure that UAMS receives funding in accordance with the terms of an award.

4. Central Administration will be responsible for approving all changes to an award to ensure that they comply with the following:
   a. Award provisions;
   b. Federal policies or guidelines that regulate the award;
   c. State regulations;
   d. UAMS regulations.

5. Central Administration will arrange for regular computer printouts showing charges to an award account and monthly payroll certification forms. Arrangements will also be made for the preparation of the final financial report and other closing documents that are required by an award. The principal investigator/project director will be responsible for the preparation of the technical report.

6. Contact the Office of Research Administration at extension 65502 for assistance and additional information.

REFERENCE
Research Administration Guide
Grants and contracts for research at the University of Arkansas for Medical Sciences are awarded to the Board of Trustees of the University of Arkansas. The University is responsible for the administration of the projects. Administrative authority may be delegated through the dean to the chairman of the department in which the principal investigator is located. With a view toward successful operation of the project, Office of Research Administration personnel, extension 65502, will assist the departments and the principal investigators in fulfilling grant and contract requirements by serving, when requested, in a liaison capacity between principal investigators and the University's staff or service offices. Controller's Office personnel, extension 66843, will address questions specifically related to grant and contract accounting and/or payroll matters.

PROCEDURE

1. The principal investigator serves as the University's grant and contract agent. The responsibilities of the principal investigator include the technical requirements and the day-to-day administration of the sponsored award.
2. Specific responsibilities of the principal investigator may be found in Appendix J of the Research Administration Guide.
3. Contact the Office of Research Administration at extension 65502 for assistance and additional information.
The overall objective of ARIA is to provide an integrated environment for the exchange of information from ORSP, IRB, Office for Clinical Trials, Animals, Biosafety, and Laboratory for UAMS campus-wide research. ARIA is designed to be a major component of a comprehensive solution for the information technology needs of administrators, researchers, and institutions while maintaining an emphasis on compliance with regulatory requirements. Through implementation of ARIA, researchers will be provided a supporting infrastructure to continue their mission to engage in activities that improve the health and well-being of people and animals.

ARIA is supported in part by the National Center for Research Resources of the National Institutes of Health.
Welcome to the General Clinical Research Center!

Supported by the National Institutes of Health's (NIH) National Center for Research Resources, the GCRC includes a six-bed inpatient facility and an outpatient clinic accommodating approximately 3,500 visits annually. The bionutrition component of the GCRC can provide constant metabolic diets and nutritional counseling. The on-site core lab can accommodate specimen handling and routing tests. The nursing staff includes six research nurses, cross trained in both pediatric and adult care. Investigators requiring data and safety monitoring boards, statistical development and analysis, and database design and storage are supported by enthusiastic, knowledgeable GCRC professionals.

The GCRC provides a safe, welcoming environment for the comfort of principal investigators and study subjects alike. A variety of room configurations allow flexibility in the way studies are conducted.

Who is eligible to participate? All UAMS faculty are encouraged to use the GCRC services. Currently active researchers include those from the Colleges of Medicine, Pharmacy, and Nursing, as well as from the VA Hospitals and Arkansas Children's Hospital.

The GCRC Mission

The primary purpose of the GCRC is to provide clinical research infrastructure to investigators in human-based research who are funded by the NIH or by federal, state, and local agencies and the private sector. The Center provides space, staff and other resources to further translational research in Arkansas and acts as a catalyst for collaboration among basic and clinical scientists.

The Center serves as an institutional resource for new clinical investigators to complete pilot studies that may result in extramural funding. The GCRC also provides educational programs and grants in support of new investigators.
Welcome to the Office for Clinical Trials

The Office for Clinical Trials (OCT) represents a joint effort by the University of Arkansas for Medical Sciences (UAMS), the Central Arkansas Veteran's Healthcare System (CAVHS), and the Arkansas Children's Hospital Research Institute (ACHRI) to create an environment in which industry-supported clinical research involving new drugs, devices, and biologics will be conducted in an ethical and efficient manner by highly-trained, qualified investigators and clinical research coordinators in accordance with appropriate federal and state laws, regulations, and guidelines, as well as local IRB policies.

Contact Information:

Office for Clinical Trials
4301 West Markham, Mail Slot 718-3
Little Rock, AR 72205-7199

Coordinator: Julia Washam RN, CDE, CCRC
Telephone: 501-686-8572
Fax: 501-526-7465
Email: washamjuliak@uams.edu

Director: Tom Wells MD, MBA
Telephone: 501-603-1638
Fax: 501-526-7465
Email: wellsthomasg@uams.edu

University of Arkansas for Medical Sciences
4301 W. Markham St., Mail Slot 718-3, Little Rock, AR 72205

Questions about this page? Send us an E-mail.
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Office of Grants and Scientific Publications

Who we serve
Most investigators are not charged for OGSP services. OGSP is funded through contracts and fee-for-service payments. Currently, OGSP supports investigators at UAMS through annual contracts with the Arkansas Cancer Research Center, College of Medicine, College of Public Health, Arkansas Center for Health Improvement, Myeloma Institute for Research and Therapy, and several departments.

OGSP works with administrators of each contracting organization to approve the use of time for various projects. Investigators whose projects fall under existing contracts are not charged for services. Projects that are not supported through existing contracts can be accepted on a fee-for-service basis.

Services Offered

Grant proposals

- Assist with project management and scheduling
- Create electronic templates according to funding agency guidelines
- Edit research plans for style, grammar, content, and adherence to guidelines
- Collect information for forms and create documents
- Assist investigators with budget development, preparation, and justification
- Electronically format all text and forms
- Work with Office of Research and Sponsored Programs and departments on internal documentation and sign-offs
- Manage final printing and submission process after editing and form preparation is complete, including hard copy and electronic submissions

Manuscripts and other documents

- Consult with authors regarding manuscript organization and data presentation
- Assist in editing manuscripts for specified peer-reviewed journals and books or other reports
- Help with electronic submission

Other Services

- Provide available NIH biographical sketches and other support documentation
- Make electronic PHS 398 forms available in Word format
- Conduct seminars on grantsmanship and abstract/manuscript writing skills

How to obtain services

Requests for assistance are evaluated and prioritized by the Director of OGSP and institutional leaders on the basis of scientific merit, institutional priority, and funding or publication potential.
To receive assistance, schedule a meeting with the OGSP Director or Assistant Director to discuss needed services and deadlines. Please note that several weeks’ or months’ notice may be required for scheduling large, multidisciplinary projects, especially for standard NIH deadlines.

Phone: 501.686.6004
Fax: 501.526.6770
Office: ACRC, Trailer #4
Mail: UAMS
4301 West Markham, # 752
Little Rock, AR 72205

Scheduling priorities
Priorities for all OGSP projects are established based on the following principles.

- Basic priorities—Grant proposals take priority over manuscripts for peer-reviewed publications.
- Types of grants—Center grants will have priority over individual investigator’s applications.
- Advance scheduling—Projects that are scheduled well in advance of the submission deadline will have priority over requests made only a short time before the deadline.
- Multiple projects from one PI—To ensure that a variety of investigators receive support, investigators requesting assistance for more than 1 application within a 2-week time frame will be asked to prioritize their projects. The highest priority project will be scheduled in accordance with OGSP policies. The other project(s) will be placed on a “waiting list.” If OGSP can help the investigator without turning away other investigators, then the project(s) on the waiting list will be added to the schedule when resources are available.
- Other priorities—When projects compete for limited time, high-priority projects from groups with a service agreement will take precedence over either low-priority projects from groups with service agreements or fee-for-service projects.
- Selection of projects—When multiple high-priority projects have the same deadline and staffing levels are not sufficient to complete all projects, the OGSP Advisory Committee will determine which projects will be completed.

Administrative structure
OGSP is an administrative component of the Arkansas Cancer Research Center and also reports to the Dean of the UAMS College of Medicine. It is guided by an Advisory Committee, which is composed of the following members or their representatives:

- Dean, College of Medicine (COM)
- Director, Arkansas Cancer Research Center (ACRC)
- Director, Arkansas Center for Health Improvement (ACHI)
- Dean, College of Public Health (COPH)
- Director, Grants & Scientific Publications (non-voting member)

The Advisory Committee meets as needed to accomplish the following tasks:

- Set overall goals and mission for the office
- Determine what projects will receive priority when more than one project competes for services during a specific time period
- Approve annual budget and fee structure for services
- Approve expansion of office in terms of personnel or services
- Ensure continued operation of the office by providing a base of financial support, space, and oversight
UAMS Office of Research and Sponsored Programs (ORSP)

The UAMS Office of Research and Sponsored Programs (ORSP) is the facilitator of the pre-award grants, contracts, subcontracts and industry-sponsored agreements process. Funding is often contingent on approval of research protocols overseen by the UAMS Institutional Review Board, a division of ORSP. The office also works with persons engaged in non-research projects and programs -- functions such as outreach programs, training and fellowships -- which have an equally important impact on funding within the medical community at UAMS. In addition, the office serves as a conduit of information on grant programs, sponsored programs, the latest funding and research news, medical fellowships, and governmental and non-governmental agencies.

Note: Retroactive to October 1, 2005, use through ARIA of the on-line Proposal Review Form, or "Blue Sheet," has become mandatory. If a login and password for the Projects module of ARIA is needed, please contact Connie (Hendrixson) Price at 526-5494 or Veda Leopard at 686-5502. If IRB protocols have been submitted through ARIA, the current account will be used. However, Ms. Price or Ms. Leopard must be contacted prior to submission of grant proposals through the Projects module of ARIA. Please contact ORSP for any required training, which will be offered in both a classroom setting and in one-on-one sessions. A class schedule will be available soon. To schedule individual sessions, please contact Ms. Price.

All grant-proposal paperwork, including the on-line Blue Sheet, must be submitted to ORSP at least 24 hours before the scheduled deadline.

ORSP is located in the Biomedical Research Center, Building One, Room 102. Operational hours are 8 a.m.-5 p.m. Monday through Friday. The office is closed during UAMS holidays.

ADDITIONAL LINKS
Grant Submission Deadlines for Major Extramural Funding Sources
Grant Submission Deadlines for UAMS Intramural Funding Sources
Submitting Information About New Grants and Honors (UAMS College of Medicine)
National Institutes of Health

- Initial Plans for Transition from PHS398 to New Electronic SF424 (R&R) for Grant Proposal Submissions
- eRA Commons
- Grant and Funding Sources, Writing Grant Proposals
- Monthly List of Grants and Awards at UAMS, Other Arkansas Institutions: FY 2005
- NIH Roadmap: Funding Opportunities and Deadlines
- Pending Progress Reports

http://www.uams.edu/orsp/index.shtm
Office of Research and Sponsored Programs - UAMS

- Types of Grant Programs
- Weekly Archive Index of Funding Opportunities and Notices

National Science Foundation: Funding

- NSF Fastlane

Arkansas Agencies/Governmental and Non-Governmental

Federal Agencies

Institutional Animal Care and Use Committee (IACUC)

Office of Research and Sponsored Programs, UAMS
4301 W. Markham St., Little Rock, AR 72205

ORSP Phone: (501) 686-5502
ORSP Fax: (501) 686-8359
IRB Hotline: (501) 526-7134
HIPAA Privacy Research Hotline: (501) 526-7135

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UAMS Institutional Review Board (IRB)

The IRB is currently a division of the UAMS Office of Research and Sponsored Programs.

Protecting the rights and welfare of research subjects is the sole purpose of the Institutional Review Board (IRB) at UAMS. The IRB committee -- which comprises healthcare providers from a variety of disciplines and lay representatives from the at-large community -- has the authority to approve, disapprove, or require modifications of research activities that fall within its jurisdiction. In addition, the IRB may work in conjunction with other university or institutional committees; however, it reviews research projects independently based upon the principle that human participants will be adequately protected.

All research projects involving human subjects must be submitted to the committee through use of the IRB forms prior to initiation of the research. Principal investigators submitting to the IRB should refer to the New IRB Investigator’s Handbook (2005 -- Version 3, Revised 9-22-2005) for specific guidelines on conduct of human research studies.

IRB REVIEW FEES

<table>
<thead>
<tr>
<th>Category</th>
<th>New Submission</th>
<th>Continuing Review</th>
<th>Payment Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Industry Funded</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a. Industry-Sponsored (FDA-ICH regulated)</td>
<td>$1,750</td>
<td>$600</td>
<td>Contract/Study Acct.</td>
</tr>
<tr>
<td>b. Industry-Supported</td>
<td>$500</td>
<td>$200</td>
<td>Contract/Study Acct.</td>
</tr>
<tr>
<td>c. Drug/Device Provided without funding support</td>
<td>$200</td>
<td>$100</td>
<td>Investigator</td>
</tr>
<tr>
<td>II. Non-federal grants, awards, gifts with no indirect (e.g., foundations, tobacco settlement)</td>
<td>$250</td>
<td>$100</td>
<td>Grant</td>
</tr>
<tr>
<td>III. No funding or departmental funds (includes CUMG)</td>
<td>$50</td>
<td>$30</td>
<td>Investigator</td>
</tr>
<tr>
<td>IV. Other (Specify) (e.g., multiple funding sources)</td>
<td>Negotiable</td>
<td>Negotiable</td>
<td></td>
</tr>
</tbody>
</table>

The IRB serves the following institutions:

- University of Arkansas for Medical Sciences (UAMS)
- Arkansas Children’s Hospital (ACH)
- Arkansas Children's Hospital Research Institute (ACHRI)
- Arkansas Department of Health and Human Services (DHHS)
- Central Arkansas Veterans Healthcare System (CAVHS)
Do you have general questions, concerns, complaints or suggestions about being a current or potential research participant? If so, please call the Institutional Review Board office at (501) 686-5667.

Institutional Review Board, UAMS
4301 W. Markham St., Little Rock, AR 72205

IRB Fax: (501) 686-7265
IRB Hotline: (501) 526-7134
HIPAA Research Privacy Hotline: (501) 526-7135

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INVESTIGATOR’S HANDBOOK

This Investigators Handbook has been provided by the University of Arkansas for Medical Sciences Institutional Review Board and the UAMS Office of Research Compliance to assist researchers in preparing their application for review of research involving human subjects in accordance with the guidelines set forth by the University.

2005 – Version 2 – Revised 06/01/2005
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REVISIONS HISTORY

With this handbook, we are instituting a new system of indicating handbook editions. The new method will consist of the year, followed by a version number and a revision date. For example, the first handbook is the 2004 – Version 1 – Revised 08/31/2004 edition.

Archived Handbook versions can be found at the link http://www.uams.edu/orc/Links/Handbooks.htm.

***************************************************************************

The 2004 – Version 2 – Revised 09/09/2004 edition was created to correct minor typographical errors and linking problems with the first edition. Changes were made to only formatting issues, not content.

***************************************************************************


NOTE: The following page numbers represent the internal document (Investigator’s Handbook), not the Adobe page numbering system:

Page 3 – UAMS IRB Meeting Schedule and Submission Deadlines
Added last sentence in first paragraph regarding official UAMS holidays.

Page 35 – IRB Protocol Submissions Requirements Using ARIA
Removed reference to Appendix I and added link to Chapter 5 – Informed Consent and the Investigator’s Checklist for Informed Consent on the IRB website.

Page 83 – Non-English-Speaking Subjects
Added link to IRB Policy 15.4, Non-English-Speaking Research Subjects.

Page 115 – University of Arkansas for Medical Sciences (UAMS) website
Corrected link to the IRB website.

***************************************************************************


NOTE: The following page number represents the internal document (Investigator’s Handbook), not the Adobe page numbering system:

Page 99 – ORC Information
Revised information including the purpose and duties of the staff of the Office of Research Compliance.

CHAPTER 1 – THE IRB AT THE UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

Page 4 - UAMS IRB Executive Committee
Added three paragraphs in a new section titled “UAMS IRB Executive Committee” and a link to the new IRB Policy 1.7 (Executive Committee).

CHAPTER 2 – WHAT IS SUBJECT TO IRB REVIEW?

Page 6 – Studies Requiring Review
Added five paragraphs in a new section titled “Studies Requiring Review”. This section includes information about research activities and a link to revised IRB Policy 1.4 (Studies Requiring Review).

CHAPTER 3 – IRB REVIEW REQUIREMENTS

Pages 15-19 – Exempt Review
Added new information regarding Exempt Review and link to IRB Policy 7.3 (Exempt Categories of Research).

Pages 19-25 – Expedited Review
Added new information regarding Expedited Review and link to IRB Policy 7.5 (Expedited Review).

Page 28
Moved Guidelines for Blood Draws in Pediatric and Adult Populations to end of Chapter 3.

CHAPTER 4 – PROTOCOL SUBMISSIONS

Page 30 – Investigator Requirements
Added information detailing the requirements for investigators and a link to IRB Policy 7.2 (Investigator Qualifications).

Page 31 – Study Closure
Revised information to state that the final report of study results should be received by the IRB within 30 days of decision to close a study.

Page 36 – Approval Bodies and Committees
Added information regarding working with committees and departments at UAMS, CAVHS, ACH, and ACHRI and a link to IRB Policy 2.2 (To Other University or Affiliated Committees/Departments).

Pages 36 and 37 – Other IRBs
Added information regarding working with other IRBs; added a link to IRB Policy 2.3 (To Other Institutions); and added information regarding the number and composition of IRB committees.
CHAPTER 4 – PROTOCOL SUBMISSIONS (continued)

Page 39 – Added information about Institutional Biosafety Committee.

Page 40 – Added information about Conflicts of Interest Committee.

Page 42 – Data Safety Monitoring Information
Added new section regarding Data Safety Monitoring requirements.

CHAPTER 5 – INFORMED CONSENT

Page 51
Changed name of section from “Informed Consent Requirements” to “Informed Consent Document Elements”

Page 52
Added new section called “Informed Consent Document Elements Information”, added information detailing that the IRB has the ability to waive all or a part of the informed consent requirements, and added link to IRB Policy 15.3 (Waivers of Signed Informed Consent Documents and Waivers of Informed Consent Elements).

Page 52
Added link to IRB Policy 15.1 (Informed Consent).

CHAPTER 6 – CONTINUING REVIEW

Pages 57 and 58
Revised the information concerning the items an investigator must provide for continuing review, including adding item number x. (Reports from Data Safety Monitoring…), and added a link to IRB Policy 7.6 (Continuing Review).

CHAPTER 8 – RESEARCH RECORD-KEEPING AND REPORTING

Page 67
Added information concerning a change in Principal Investigator (PI).

Pages 68 and 69
Added information about Unanticipated Problems time frame in chart and a link to new IRB Policy 10.3 (Principal Investigator IRB General Reporting Requirements).

Page 70
Added information about reporting a death or Serious Adverse Event (AE).
CHAPTER 8 – RESEARCH RECORD-KEEPING AND REPORTING (continued)

Pages 72
Added new section and link to IRB Policy 2.6 (Reporting To Appropriate Federal Oversight Bodies, Institutional Officials And Research Sponsors).

Page 72
Added new section (Changing Study Protocol/Modifications to Previously Approved Research).

CHAPTER 9 – EMERGENCY SITUATIONS

Pages 74-76
Added revised information regarding IRB Policy 18.3 (Emergency Use of A Drug or Biologic).

Pages 76-78
Added revised information regarding IRB Policy 18.4 (Emergency Use of an Unapproved Medical Device).

CHAPTER 11 – INVESTIGATIONAL DRUGS AND MEDICAL DEVICES

Page 83
Added links to IRB Policies 7.3 (Exempt Categories of Research) and 7.5 ( Expedited Review) in the Using Investigational New Drugs section.

Pages 85-86
Added new section (Sponsor-Investigator’s Responsibilities Related To Investigational New Drugs)

CHAPTER 12 – RESEARCH INVOLVING VULNERABLE POPULATIONS

Page 90
Added new information regarding research involving children.

Pages 90-91
Revised definition of children in the state of Arkansas.

Pages 91-93
In the Categories of Research Involving Children, changed the word “subjects” to “participants” and revised Pediatric Risk Categories I – IV.

Page 95
Added new information regarding Prisoners in Research

Page 98
Added link to revised IRB Policy 17.2 (Cognitively Impaired Persons).
CHAPTER 12 – RESEARCH INVOLVING VULNERABLE POPULATIONS (continued)

Page 99
Added new section, Legally Authorized Representative (LARS) and link to new IRB Policy 17.13 (Legally Authorized Representatives).

Page 102
Added new section, Research in Nursing Homes, and link to revised IRB Policy 17.4 (Subjects in Long Term Care).

CHAPTER 13 – PAYMENT/REIMBURSEMENT OF RESEARCH SUBJECTS

Pages 104-105
Deleted section “Payments to Subjects” and added new section “Subject Compensation”

Pages 105-106
Added new section “Recruitment of Study Subjects”

CHAPTER 15 – IRB AUTHORITY IN NON-COMPLIANCE ISSUES

Pages 111-112
Added two new paragraphs regarding non-compliance at the end of the Non-Compliance Issues section.

Page 112
Revised information regarding the time frame to submit the final report of study results during a study closure.

CHAPTER 19 – GLOSSARY

Pages 124-139
Deleted 1 glossary item:
Investigator/Sponsor

Revised 7 glossary items:
- Assent
- Human Subject
- In Vitro Fertilization
- Pregnancy
- Research
- Sponsor
- Standard Operating Procedures (SOPs)
Added 64 new glossary items:

- Adult Risk
- Adult Minimal Risk
- Approved
- Approved With Major Revisions
- Approved With Minor Revisions
- Clinical Investigation
- Consumer Preference Testing
- Continuing Non-Compliance
- Current Good Manufacturing Practices (Cgmp)
- Current Good Tissue Practices (Cgtp)
- Data And Safety Monitor
- Data And Safety Monitoring Board (Dsmb)
- Data Safety Monitoring Plan (Dsmp)
- Dead Fetus
- Declined
- Expired Studies
- Fda Acknowledgment Letter
- Federal Oversight Body
- Fetus
- Food And Drug Administration (Fda)
- Funding Source
- Good Clinical Practices (Gcp)
- Human Subject Research
- Imminent Threat Of An Ae In Research
- Ind Monitoring Plan
- Irb Authorization Agreement
- Irb Of Record
- Interaction
- Intervention
- Investigational Agents
- Investigational Devise
- Investigational Drugs/Investigational Biologics
- Investigational Device Exemption (Ide)
- Investigational New Drug (Ind)
- Legally Authorized Representative (Lar)
- Non-Compliance
- Non-Human Subject Research
- Non-Significant Risk (Nsr) Device Study
- Nonviable Fetus

VI
CHAPTER 19 – GLOSSARY (continued)

Added The Following New Glossary Items:

- Pediatric Risk Category I
- Pediatric Risk Category II
- Pediatric Risk Category III
- Pediatric Risk Category IV
- Private Information
- Related Event
- Scientific Misconduct
- Serious Adverse Event
- Serious Event
- Serious Non-Compliance
- Significant Risk (Sr) Device Study
- Sponsor/Investigator
- Substantive Action By The Irb
- Suspended For Cause
- Tabled
- Terminated For Cause
- Test Article
- Treatment Ide
- Unanticipated Adverse Device Effect
- Unanticipated Event
- Unanticipated Problem Involving Risks To Participants Or Others
- Unanticipated Adverse Event
- Unexpected Event
- Viable
- Waiver
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<tr>
<td>3</td>
<td>3</td>
<td>The Membership and Structure of the UAMS IRB</td>
<td>Added information that two VA members appointed by CAVHS are members of the UAMS IRB.</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
<td>UAMS IRB Meeting Schedule and Submission Deadlines</td>
<td>Added information that meetings are usually held on the first four Tuesdays of each month and that deadline adjustments can be made at the discretion of the IRB Chair.</td>
</tr>
<tr>
<td>4</td>
<td>4</td>
<td>UAME IRB Executive Committee</td>
<td>Deleted the information regarding the Assistant Vice Chancellor for Research will serve as Chair of the Executive Committee and added the information that Legal Counsel and a representative from the CAVHS Research and Development committee are ad hoc ex-officio members of the Executive Committee.</td>
</tr>
<tr>
<td>6</td>
<td>6</td>
<td>Scope of IRB Review</td>
<td>Deleted the Arkansas Department of Health (ADH) from the list of institutions requiring IRB review and approval.</td>
</tr>
<tr>
<td>7</td>
<td>7</td>
<td>Research Review Requirements</td>
<td>Revised the definition of clinical investigations as any experiment that involves the use of an FDA regulated product.</td>
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<td></td>
<td>Revised the information in the example text box.</td>
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<td></td>
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<td></td>
<td>Deleted the last bullet item: “Is the proposed activity intended to fulfill requirements fulfill requirements for a master’s thesis, doctoral dissertation, or other research requirement?”</td>
</tr>
</tbody>
</table>
## Research Conducted By Students and Residents

Revised the 4th bullet number to read “Establish and maintain strict guidelines for protecting privacy and confidentiality” by replacing the word anonymity with privacy.

## When is IRB Review Required?

Deleted the citation 45CFR from the list of federal regulations.

## Type of IRB Review For New Protocols

In the three categories of review chart, under the heading Exempt Review; the first sentence was revised to read “Some research falls into a category of research called exempt.”

## Exempt Review

Changed all references from IRB Chair to IRB Chair/Designee

## Categories of Exemption (Per 45 CFR 46.101)

Deleted “From IRB Review” from section title.

## Expedited Review (Per 45 CFR 46.110)

Deleted the following sentence from the first paragraph “Decisions reached at the convened meetings may supercede any decisions made through the expedited review.”

## For a new protocol to qualify for Expedited Review, the research must:

Added the sentence “For a new protocol to qualify for Expedited Review, the research must:”

Revised the wording in items 2-4.
### Categories of Expedited Review for New Protocols

- Deleted items 8 and 9 and changed the section heading as “Continuing review of research by the expedited procedure must meet one of the following criteria:”
- Added numbers 1-5
- Revised the paragraph regarding modifications.
- Changed “Procedure” to “Investigator Procedure”.

### Investigator Procedure

- Changed item #1 to “For Initial Review of an Expedited Protocol, Investigator must:”
- Revised items 1.1, 1.2, 2, 2.1, 3, and 3.1.

### IRB Procedure

- Renamed section heading “IRB Procedure”
- Changed item #1 to “For Initial Review of an Expedited Protocol, IRB Chair/Designee must:”
- Revised items 1.1, 1.2, 1.3, 1.4, 1.5, 1.6, 2, 3, and 3.1.
- Deleted last two sections.
## 2005 – Version 2 – Revised 06/01/2005 (Continued)

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<td>25</td>
<td>25</td>
<td><strong>Full Review</strong></td>
<td>Revised information regarding a quorum.</td>
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<tr>
<td>26</td>
<td>25</td>
<td><strong>IRB Review Results</strong></td>
<td>Revised “Protocol Approval Deferred (Major or Minor):”</td>
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<td>26</td>
<td>25</td>
<td></td>
<td>Revised “Protocol Tabled:”</td>
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<td>26</td>
<td>25</td>
<td></td>
<td>Revised “Protocol Declined:”</td>
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<td>26</td>
<td>25</td>
<td></td>
<td>Deleted “Protocol Disapproved:”</td>
</tr>
<tr>
<td>30</td>
<td>30</td>
<td><strong>Definition of Research</strong></td>
<td>Revised the definition of research.</td>
</tr>
<tr>
<td>31</td>
<td>30-31</td>
<td><strong>Responsibilities Of The Principal Investigator When Submitting A Study For IRB Approval</strong></td>
<td>Revised 2nd paragraph regarding CRR.</td>
</tr>
<tr>
<td>31</td>
<td>31</td>
<td><strong>Study Closure Information</strong></td>
<td>Revised last sentence to read “Studies are not to be closed until the Investigator has determined that the study no longer needs access to any identifiable information.”</td>
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<tr>
<td>31-32</td>
<td>31-32</td>
<td>The PI is responsible for abiding by the Investigator’s Agreement that includes the following items:</td>
<td>Deleted bullet #4 “Any unexpected serious problem, such as:…”</td>
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<tr>
<td>34</td>
<td>34</td>
<td>Specifying the Number of Research Subjects</td>
<td>Deleted the 2nd paragraph “Enrolled Subjects are subjects are defined as those who met eligibility criteria and gave informed consent to participate in the larger study.”</td>
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<td>36</td>
<td>36</td>
<td>Approval Bodies and Committees</td>
<td>Deleted the last sentence in the 1st paragraph “If gaining institutional committee letters cause a significant delay, the Investigator may submit copies of his letters requesting approval with the submission to the IRB.”</td>
</tr>
<tr>
<td>36-37</td>
<td>36</td>
<td>Other IRBs</td>
<td>Deleted the last part of the first sentence, “OR the UAMS IRB must have a monitoring plan for the other IRB.”</td>
</tr>
<tr>
<td>39</td>
<td>39</td>
<td>VA R &amp; D Committee</td>
<td>Revised the first paragraph by deleting item # (1) Principal Investigator receives any salary from the VA.</td>
</tr>
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<td>42</td>
<td>42</td>
<td>Data Safety Monitoring Information</td>
<td>Revised first paragraph.</td>
</tr>
<tr>
<td>43</td>
<td>43</td>
<td>Application Forms and Original Signatures</td>
<td>Deleted the second sentence in the text box “The IRB must approve the alternate or formally authorized signatory.”</td>
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<tr>
<td>44</td>
<td>43-44</td>
<td>Information From The Following Documents Is Needed For Protocol Submissions Via ARIA:</td>
<td>Added the following sentence to 2nd bullet regarding the consent form “If a DHHS approved sample consent exists, provide it as well and justification for any substantial deviations.”</td>
</tr>
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### Version 1 Page # | Version 2 Page # | Section Title | Revision
---|---|---|---
45-49 | 45 | **How To Submit A New Study Protocol Using ARIA** | Revised the instructions by deleting the sections “How To Submit A New Behavioral Study Protocol Using ARIA” and “How To Submit A New Biomedical Study Protocol Using ARIA” and renaming the section “How To Submit A New Study Protocol Using ARIA”.

54 | 50 | **Exceptions From The Standard Informed Consent Procedures** | Deleted the section “Obtaining Informed Consent in Emergency or Compassionate Situations”.

55 | 51 | **Waiver of the Requirement to Obtain Prospective Informed Consent From Subjects in Non-Emergency Research** | Deleted the last sentence in the 2nd paragraph “Consent waivers will be discussed during a meeting of the convened IRB.”

57 | 53 | **Continuing Review General Information** | Revised information to say that Continuing Review must occur at least once per year instead of every 365 days.

57 | 53-43 | **IRB Continuing Review Requirements Using ARIA** | Deleted the 4th paragraph “Each PI needs a username and password to access the ARIA system. For assistance with obtaining an ARIA username and password, please contact the IRB office at 501-686-5667.”

58 | 54 | **IRB Continuing Review Process** | Revised the information from “Federal regulation require IRB Continuing Review approval every 365 days” to “at least once per year.”
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<tr>
<td>58-60</td>
<td>54-56</td>
<td><strong>IRB Continuing Review Process</strong></td>
<td>Following the sentence “Protocols more likely to be reviewed at least every six months include:” deleted the bullet items and replaced them with items a-h. Deleted the bullet items regarding a status report and changed it to a Continuing Review Report.</td>
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<td>59</td>
<td>56</td>
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<tr>
<td>59-60</td>
<td>56</td>
<td><strong>Continuing Review Ruling are as follows:</strong></td>
<td>Changed Protocol Re-approval to Protocol approval. Changed Protocol Re-approval Deferred (Major or Minor) to Protocol approval Deferred (Major or Minor) and also revised the last sentence to read “This information must be received as requested by the IRB,” by deleting “or the study may be out of compliance and the Investigator must stop enrollment.’</td>
</tr>
<tr>
<td>60</td>
<td>56</td>
<td><strong>Important Reminders</strong></td>
<td>Revised the last paragraph to read “All protocols not approved by the IRB by the project’s continuing review expiration date are no longer approved. All new accrual must cease and all further subject (or data) interactions must cease unless specifically approved by the IRB due to subject safety concerns.”</td>
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<tr>
<td>61</td>
<td>57</td>
<td><strong>Continuing Review Summary Information</strong></td>
<td>Deleted last paragraph.</td>
</tr>
<tr>
<td>63</td>
<td>69</td>
<td><strong>Protocol Amendments</strong></td>
<td>Changed “patient” to “participant” in 1” sentence in the 2nd paragraph.</td>
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</table>
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<tr>
<td>65</td>
<td>61</td>
<td>ARIA Information</td>
<td>Changed “All Serious Adverse Event (SAE) reporting” to “All reporting” in 1st sentence.</td>
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<tr>
<td>65-66</td>
<td>61-62</td>
<td>Record-Keeping Responsibilities Of The Principal Investigator</td>
<td>“Reports of unanticipated problems involving risks to participants or others” replaced “Reports of deaths, protocol violations, protocol deviations and serious adverse events” in the text box.</td>
</tr>
<tr>
<td>68-69</td>
<td>64-65</td>
<td>Reporting Responsibilities Of The Principal Investigator To The IRB</td>
<td>Revised information in the “Investigator Must Report” and “Time Frame for Reporting” columns.</td>
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<tr>
<td>69-70</td>
<td>65-66</td>
<td>Adverse Event Reporting</td>
<td>Revised information in this section.</td>
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<td>71</td>
<td>67</td>
<td>Reporting Notification Of Pending Audits Or Inquiries</td>
<td>Revised information in this section.</td>
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<td>90</td>
<td>86</td>
<td>Background Information</td>
<td>Removed “Veterans” from the list of Other Potentially Vulnerable Populations.</td>
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<td>113</td>
<td>109-110</td>
<td>Suspension</td>
<td>Revised section by removing bullet item #9.</td>
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</table>
CHAPTER 1

The IRB At The University of Arkansas For Medical Sciences

Protecting human subjects involved in research is a collaborative effort that demands the vigilance of UAMS faculty, staff, and students in partnership with the local community, federal agencies and agencies sponsoring research. This guide is intended to help researchers meet their responsibilities.

The Purpose of the University of Arkansas for Medical Sciences Institutional Review Board
Authority and Responsibility of the UAMS IRB
The membership and structure of the UAMS IRB
UAMS IRB Meeting Schedule and Submission Deadlines
UAMS IRB Executive Committee
The Purpose Of The University Of Arkansas For Medical Sciences Institutional Review Board

The purposes of the University of Arkansas for Medical Sciences (UAMS) Institutional Review Board (IRB) are:

- To protect the rights and welfare of human research subjects.
- To approve the initiation of and conduct periodic reviews of biomedical and behavioral research involving human subjects.
- To terminate or suspend studies in human subjects.

The UAMS Institutional Review Board (IRB) is the deliberative body designated by the following institutions, among others:

- University of Arkansas for Medical Sciences (UAMS)
- Arkansas Children’s Hospital/Arkansas Children’s Hospital Research Institute (ACH/ACHRI)
- Central Arkansas Veteran’s Healthcare System (CAVHS)
- Arkansas Department of Health (ADH)

This committee operates according to Federal, State, Institutional and Good Clinical Practices (GCP) guidelines. The UAMS IRB also recognizes the tripartite International Code of Harmonization (ICH).

The UAMS IRB has the authority to approve, disapprove or require modifications of research activities that fall within its jurisdiction. The UAMS IRB may work in conjunction with other university or institutional committees; however, it reviews research projects independently based upon the principle that human participants will be adequately protected.

Authority and Responsibility of the UAMS IRB

The UAMS IRB operates under a Federalwide Assurance (FWA). This is an agreement between the UAMS IRB and the Department of Health and Human Services (DHHS), which outlines the responsibilities of the UAMS IRB for upholding the ethical principles regarding research involving human subjects. These principles are outlined in the report of the National Commission for the Protection of Human Subjects in Biomedical and Behavioral Research titled, *Ethical Principles and Guidelines for the Protection of Human Subjects of Research* (known as the “Belmont Report”).

The Office for Human Research Protections (OHRP) oversees research activities for DHHS. The Office of Research Oversight (ORO), formerly the Office for Research Compliance and Assurance (ORCA) also oversees studies involving veterans. Other agencies that the IRB report to include: The Food and Drug Administration (FDA), The Office of Research Integrity (ORI), institutional officials, sponsors, and funding agencies.

Normally, the IRB will agree to serve as the institutional review board for other institutions only if a staff member or faculty appointee of UAMS is involved as a Principal or Sub-
Investigator. However, the IRB will serve any state agency for a specific protocol by written request. Many ACH, CAVHS, ADH, NCTR, and ASH scientists have academic appointments at UAMS and in general will utilize or collaborate with clinical faculty of UAMS for their human studies. Appropriate agreements between the committee and the requesting institution will be required.

The Membership and structure of the UAMS IRB

The Vice Chancellor for Academic Affairs and Research Administration (VCAA/RA) at UAMS appoints members of the IRB, including the Chair. Appointments are generally for four-year periods. Federal requirements mandate that the IRB must have at least five members of varying backgrounds to promote complete and adequate review of research activities commonly conducted at this institution. IRB members must be knowledgeable about institutional commitments and regulations, applicable laws, standards of professional conduct, and practice. The IRB membership must be diverse in matters of race, gender, and cultural background; and include at least one person in each of the following categories:

- The member’s primary concern is the scientific area
- The member’s primary concern is the non-scientific areas
- The member is not affiliated with the institution and is not an immediate family member or a person who is affiliated with the institution.
- In order to review studies at CAVHS, two VA members appointed by CAVHS
- Other representatives are present to consider protocols involving children and prisoners.

No member of the IRB may participate in the initial or continuing review of any project in which that member has a conflicting interest, except to provide information requested by the IRB. IRB members include healthcare providers from a variety of disciplines and lay representatives from the community at large.

UAMS IRB Meeting Schedule and Submission Deadlines

The Biomedical Institutional Review Board (IRB) typically meets on the first four Tuesdays of each month. Meetings are held at 2:00 p.m. on the UAMS campus. The deadline for submission of protocols for IRB review is 10:00 a.m. two weeks prior to the scheduled meeting. Submissions not received in the IRB office by that day and time are held over for consideration at the next meeting. Deadline adjustments can be made at the discretion of the IRB Chair. In addition, official UAMS holidays may sometimes require an adjustment in the meeting dates.

The Behavioral and Social Sciences Institutional Review Board (IRB) meets the second Thursday of each month on the UAMS campus. The Behavioral and Social Sciences IRB studies reviewed by this committee are considered medically non-invasive and include studies involving questionnaires, surveys, interviews, focus groups, etc.

Select Meeting Dates and Deadlines may be found on the UAMS IRB website.
UAMS IRB Executive Committee

The Executive Committee is maintained as an active resource to identify new IRB policies and procedures necessary to ensure the efficient operation of the IRB Administrative Office and IRB Committees and to ensure compliance with the standards of human subject protections as set forth in the Belmont Report and federal, state and institutional rules and regulation. Minutes of each Executive Committee meeting will be maintained and signed by the Executive Committee Chair.

The Executive Committee consists of the Vice Chancellor for Academic Affairs and Research Administration (VCAA/RA), the Chairpersons of each IRB Committee, the Office of Research and Sponsored Programs (ORSP) Director and Associate Director, and the Office for Research Compliance (ORC) Director. Legal Counsel and a representative from the CAVHS Research and Development Committee are ad hoc ex-officio members of the Executive Committee. In addition, IRB Committee members, Investigators, or other individuals will be invited to the meetings as their presence is warranted.

For more information, see IRB Policy 1.7 (Executive Committee).
CHAPTER 2

What Is Subject To IRB Review?

The scope of the Institutional Review Board's (IRB) charge is broad. Generally, any University research that uses humans, human tissue, surveys of human subjects, human subjects’ records, or in some cases human cell lines requires IRB review, irrespective of its funding source. The IRB's charge extends to research in the social and behavioral sciences as well as research in the health and biological sciences.

Scope of IRB Review
Studies Requiring Review
Research Requirements
Research Conducted By “Affiliated Faculty”
Research Projects In Which The Researcher Is A Consultant
Research Conducted By Students And Residents
Research Training
Research Conducted At Other Institutions
Research That Is Part Of Multicenter Clinical Trials
Research In Foreign Countries
IRB Review
Research Involving Secondary Use Of Data
Scope Of IRB Review

IRB review and approval is required for any research involving human subjects if a staff member or faculty appointee of University of Arkansas for Medical Sciences (UAMS), Arkansas Children’s Hospital (ACH), or Central Arkansas Veteran’s Healthcare System (CAVHS) is involved as a Principal Investigator or Sub-Investigator. However, the IRB will serve any state agency for a specific protocol by written request and once appropriate agreements are in place. IRB will review research that meets any of the following criteria:

- Research conducted or sponsored by faculty, staff, students, or employees of the respective institution.
- Research performed on the premises of UAMS and associated institutions.
- Research performed with equipment or in facilities belonging to UAMS.
- Research that involves UAMS patients, students, staff, or faculty.
- Research that involves UAMS patient data.
- Satisfies a requirement imposed by the University for a degree program or for completion of a course of study.
- Certified by a dean or department head to satisfy an obligation of a faculty appointment at the University, including clinical or adjunct appointments.

Studies Requiring Review

All activities, regardless of whether the activity requires full board review, or might qualify for one of the expedited or exempt categories, that are clearly Human Subject Research should submit a complete proposal, including protocol, to the IRB through either a New Biomedical Protocol Submission or a New Behavioral Submission in ARIA. No human Subject Research study should be initiated prior to IRB approval.

The IRB has sole authority to determine whether an activity meets the definition of Human Subject Research. Any activity that might represent Human Subject Research should be submitted to the IRB for determination.

All research activities, including those deemed Non-Human Subject Research, must be carried out in an ethical and respectful fashion in compliance with the principles of the Belmont Report, all state and local laws and institutional policies.

Research conducted by, or under the direction of, any employee, faculty, staff or student of UAMS or any entity in which the UAMS IRB is designated as the IRB of record, is governed by these policies. This includes research conducted off site or research involving the use of non-public information to identify or contact human research participants or prospective participants.

To determine if a study is a human research study, please follow the procedure in IRB Policy 1.4 (Studies Requiring Review).
Research Review Requirements

According to the United States Code of Federal Regulations, 45 CFR 46.102(d), Research means a systematic investigation, including research development, testing, and evaluation designed to develop or contribute to generalized knowledge. Examples of research activity include:

- Clinical trials
- Surveys
- Interviews
- Behavioral investigations
- Prospective or retrospective reviews of medical information
- Experiments with physiological fluids and tissue
- Demonstration or service programs.

The Food and Drug Administration (FDA) includes under the definition of reviewable research, clinical investigations defined as any experiment that involves the use of an FDA regulated product.

Example: Use of an FDA approved cardiac medicine in a research project studying the medicine’s impact on the treatment of neurogenic pain would be considered a clinical investigation and be subject to IRB review.

To determine whether a proposed activity is research, apply the following criteria in conjunction with IRB Policy 1.4. If there are any questions about whether a proposed project rises to the level of human subject research, email a project description to irb@uams.edu:

- Is the proposed activity intended for release to the Scientific Community as a contribution to knowledge? For example, publication in a medical or scientific journal and/or presentation at a medical or scientific meeting.
- Does the proposed activity involve an interaction or intervention with a living person that occurs solely for the purpose of the project?
- Will the proposed activity collect identifiable, private data/information in a form that is associable with the individual?
- Is the proposed activity portrayed (explicitly or implicitly) by university students, faculty, or staff as “research” or “experimental” investigation?

If any one of the above criteria is answered “yes”, the protocol must be reviewed and approved by the IRB.

The IRB, not the Investigator, determines if an activity is research.
Research Conducted By “Affiliated Faculty”

Research conducted by "affiliated faculty" -- faculty members who hold clinical or adjunct appointments--is subject to the University's guidelines for research on human subjects and must be submitted for IRB review. Any research project that is conducted by or under the direction of any employee or agent of this institution, in connection with his or her institutional responsibilities, requires IRB approval.

Research Projects In Which The Researcher Is A Consultant

UAMS IRB review is required unless the researcher has a strict consulting relationship in which:

- The researcher is hired on his or her own time and does not use Institutional resources.
- The researcher holds no rights in the work.
- Neither the researcher nor the institution retains any data.

All three of these criteria must be met, or the IRB will need to review the project.

Research Conducted By Students and Residents

Independent class projects, senior theses, undergraduate research projects, master's projects, partial fulfillment of fellowship requirements, and similar exercises utilizing human research must be independently submitted to the IRB by the student/resident-researcher but a physician/faculty member ultimately is responsible for the protection of the subjects and should be listed as the Responsible Staff Person in ARIA. Advisers shoulder the responsibility for students or residents engaged in independent research, and instructors are responsible for research that is conducted as part of a course. Because students and residents are transient, the faculty member sponsor must rigorously defend why they are not the Principal Investigator for such projects.

During the design of a project, advisors and faculty members should instruct students and residents on the ethical conduct of research and help them prepare applications for IRB approval. In particular, students and residents should do the following:

- Understand the elements of informed consent.
- Develop a readable consent form written in the second person and at a level equivalent to an eighth grade education.
- Plan appropriate recruitment strategies for identifying subjects.
- Establish and maintain strict guidelines for protecting privacy and confidentiality.
- Allow sufficient time for IRB review and completion of the project during the student or resident’s matriculation.
- Obtain certificates for required Human Subject Training and HIPAA for Research.
As assurance that the University's guidelines will be followed, the adviser or instructor is required to be listed as the Responsible Staff Person in ARIA for the student's/resident's application for IRB approval and/or serve as the Principal Investigator.

After IRB approval, faculty members should take an active role in ensuring that projects are conducted in accordance with the IRB's requirements. One way to meet this responsibility is to meet periodically with students/residents to review their progress and to assist in submitting the continuing reviews required by the IRB.

Research Training

The Office of Research Compliance functions as the auditing and compliance body as well as the training unit for the UAMS Institutional Review Board. This office is a component of the campus’ Human Research Protections Program (HRPP) and reports directly to the senior research official at UAMS, the Vice Chancellor for Academic Affairs and Research Administration (VCAA/RA).

The ORC offers both the Online Human Subject Protection Training and the Online HIPAA For Research Training courses at [http://www.uams.edu/orc/Training/Training.htm](http://www.uams.edu/orc/Training/Training.htm).

Research Conducted At Other Institutions

For a UAMS researcher to participate in a research project at another site, the project needs to be reviewed by the UAMS IRB as well as by the other institution's IRB. For example, a UAMS researcher engaged in research at the CAVHS must secure approval from both the UAMS IRB and the CAVHS R&D Committee.

The UAMS IRB tries to accommodate researchers who work at multiple sites by streamlining the IRB approval process. In some cases, reciprocal review and approval arrangements with the UAMS IRB relieve the Investigator of obtaining the independent approval of two IRBs. For more information, contact the IRB at irb@uams.edu.

Researchers who must submit a project to another IRB should work closely with the UAMS IRB to ensure that the appropriate agreements are in place prior to submitting to the UAMS IRB. The researcher may be asked to submit copies of the application and review of the non-UAMS IRB. Changes in protocol or consent forms required by the other IRB should be brought to the attention of the UAMS IRB.

Research That Is Part Of Multicenter Clinical Trials

Approval of a proposal document at the national level is not sufficient to bypass approval at the local level. Researchers who conduct multicenter clinical trials sponsored by the National Institutes of Health (NIH) or the National Cancer Institute (NCI), for example, should include protocols and consent forms approved at the national level with their applications to the UAMS IRB. Although the documents should be identified as having been approved by a national IRB, the local IRB must review the material as it would any other submission. (OHRP Report Number 93-01).

Only the local IRB is vested with the authority to review and approve projects to be conducted at a given institution familiar with the particular circumstances of its research.
setting and is able to weigh critical considerations such as state and local laws, professional and community standards, institutional policies, and the needs of different patient and subject populations.

If changes are made to documents approved by the national IRB, the Investigator must provide timely notification to the IRB. The UAMS IRB will rarely make substantive changes in the protocol or study plan and are more likely to request that the wording of a consent form be changed to reflect local standards or to include specific language required by the University.

❖ Research In Foreign Countries

Research conducted by UAMS Investigators in foreign countries remains under University purview and guidelines. While the University cannot impose its standards for written documentation on other cultures, it does not relax its standards for ethical conduct or consent process.

The Office for Human Research Protections (OHRP) can determine whether procedures described by a foreign institution afford protections that are at least equivalent to U.S. regulations [45 CFR 46 101 (h)]. Under this provision, OHRP investigates the foreign country's guidelines for human subject research, and if the foreign guidelines are found to be equivalent to U.S. regulations, the Investigator is permitted to substitute those foreign procedures.

Researchers proposing international research should allow additional time for this review process.

❖ IRB Review

In performing reviewing tasks, the IRB shall request documentation of the following:

1) That the foreign study is done under the oversight of an IRB or Ethics Board in country of origin.
2) Subjects must have signed an IRB Ethics Board approved consent form.
3) If samples are involved,
   - ascertain if they are de-identified and when they will be destroyed.
   - that the PI will use them only for the methods in the signed consent form.

❖ Research Involving Secondary Use of Data

Projects that use data on human subjects gathered in earlier projects require IRB review.

If the data are gathered by someone who has legitimate access to the records and who gives the Investigator only "blinded" or de-identified data (so that the Investigator is unable to identify the subjects), the level of risk is lowered.
CHAPTER 3

IRB Review Requirements

This chapter defines the different types of IRB review for new protocols.

When is IRB Review Required?
Definition of Research
Definition of Human Subjects and Ethical Considerations
IRB Review Requirements
Assigning Study Risk Category and Frequency of Continuing Review
Reporting

Types of IRB Review For New Protocols

- Exempt Review
- Expedited Review
- Full Review

IRB Review Results

Notification of Investigators Following Review
Notification of Institutional Officials
Guidelines for Blood Draws in Pediatric and Adult Populations
When is IRB Review Required?

All research or clinical investigations involving human subjects or data related to human subjects, and all other activities that even in part involve such research, regardless of sponsorship, must be reviewed and approved by the IRB. No intervention or interaction with human subjects or their data in research, including recruitment, may begin until the IRB has reviewed and approved the research protocol [45CFR46.101; 21CFR56.103(a)].

Definition of Research

Research is a systematic investigation, including research development, testing, and evaluation designed to develop or contribute to generalized knowledge [45CFR46.102(d)]. Examples of research activity include clinical investigations, clinical trials, surveys, interviews, behavioral investigations, retrospective reviews of medical information, experiments with blood and tissue, and demonstration or service programs.

Definition of Human Subjects and Ethical Considerations

A human subject is defined in Title 45 of the Code of Federal Regulations, Section 46.102 (f) as a living individual about whom a professional or student Investigator conducting research obtains data through intervention or interaction with the individual or collects identifiable private information. Human subjects are also defined as an individual who is or becomes a participant in research, either as a recipient of a test article or as a control. A “subject” may be a healthy human or a patient [21 CFR 56.102 (e)].

The Nuremberg Code is the first in a series of codes of ethical conduct for modern researchers. The use of human subjects for research demands that the Investigator have a working knowledge of pertinent rules and regulations. One of the strongest threads binding the many rules and regulations together is the distinction between research subject (participant) and patient. If the activity that is planned for the subject is less effective or more dangerous than standard care, it is not “ethical” for that person to become a research subject except under notable exceptions. It is the ethical obligation of the Investigator to make findings widely known and eliminate unnecessary risk to the former subject and patients.

In its review of human subject research, the IRB has jurisdiction over all aspects of research including:

- Methods of identifying potential subjects
- Methods proposed for contacting potential subjects
- Materials to recruit subjects and proposed compensation
- Pilot studies
- Proposals to use or provide stored blood, tissues, or confidential data
- Surveys and questionnaires
- The informed consent process and forms
• The protocol and summary of the research
• Any risks to subjects from the proposed research are reasonable in relationship to anticipated benefits
• Proposed changes to the research
• Unanticipated problems involving risk to the subject or others
• Continuing reviews
• Uses of investigational drugs and devices in emergencies
• Humanitarian uses of drugs and devices
• Determination of a protocol’s eligibility for waiver of full review

The submission of any study for initial review should address those issues listed above that are pertinent to the protocol.

❖ **IRB Review Requirements**

The IRB is required by CFR 45 46.111 to consider all of the following during its review of proposed studies and continuing reviews:

• The IRB is required to assure that the selection of subjects is equitable and should be particularly cognizant of the special problems of research involving vulnerable populations such as children, prisoners, pregnant women, mentally disabled persons or economically or educationally disadvantaged persons.

• Risks to subjects are minimized through the use of procedures consistent with sound research.

• Risks to subjects are reasonable in relation to anticipated benefits and to the knowledge that may reasonably result.

• Informed consent is correctly obtained and appropriately documented, unless meeting the criteria for a waiver.

• Subject privacy and confidentiality of the subject data is maintained.

• The research plan makes adequate provision for the monitoring of data to ensure subject safety.

❖ **Assigning Study Risk Category And Frequency Of Continuing Review Reporting**

The IRB committee meetings include a discussion and vote on new protocols, major modifications, and studies submitted for continuing review. New protocols are assigned categories of risk and frequency of continuing review. In order to approve research, the IRB must determine the degree of risk.
Below is the definition of risk categories derived from 45 CFR 46.

<table>
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<tbody>
<tr>
<td>Minimal Risk</td>
<td>Greater Than Minimal Risk</td>
</tr>
<tr>
<td><strong>Activity where the probability and magnitude of harm or discomfort anticipated in the research is not greater in and of themselves than those ordinarily encountered in daily life or during performance of routine physical or psychological examinations or tests.</strong></td>
<td><strong>Research involving greater risk of harm than ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests, but presenting the prospect of direct benefit to the individual subjects; or the research presents no prospect of benefit to the subject, but is likely to yield knowledge about the disorder or condition.</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pediatric Category 1</th>
<th>Pediatric Category 2</th>
<th>Pediatric Category 3</th>
<th>Pediatric Category 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimal Risk</td>
<td><strong>Greater than minimal risk, but presenting the prospect of direct benefit to individual subjects</strong></td>
<td><strong>Greater than minimal risk and no prospect of direct benefit to individual subjects but likely to yield important generalizable knowledge about the subject’s disorder or condition.</strong></td>
<td><strong>Otherwise not approvable, but presents an opportunity to understand serious health or welfare problems of children</strong></td>
</tr>
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</table>

New Protocols not eligible for expedited review will be reviewed by at least two IRB members chosen on the basis of expertise with the particular subject matter of the study. These individuals will serve as the Primary Reviewers and will be responsible for presenting the protocol to the convened IRB for discussion.

The IRB must deliberate on all studies classified as greater than minimal risk for the purpose of assigning the frequency of continuing review reports. The IRB may decide to review greater than minimal risk studies more frequently than every twelve months.
Type of IRB Review For New Protocols

There are three categories of review:

<table>
<thead>
<tr>
<th>Exempt Review</th>
<th>Expedited Review</th>
<th>Full Review</th>
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<tbody>
<tr>
<td>Some research falls into a category of research called</td>
<td>The proposed research is defined as minimal risk and</td>
<td>Research involves issues that do not qualify for exempt</td>
</tr>
<tr>
<td>exempt. Examples of this category are listed in 45 CFR</td>
<td>within one of the OHRP approved expedited categories.</td>
<td>or expedited review.</td>
</tr>
<tr>
<td>46.101. NOTE: Exempt research must be still be submitted</td>
<td>Review by the fully convened IRB is not necessary.</td>
<td>The research is reviewed by 2 Primary Reviewers who</td>
</tr>
<tr>
<td>to the IRB through ARIA for classification as Exempt by</td>
<td>Approval may be given by the IRB Chair/Designee and</td>
<td>present their findings to a fully convened IRB for</td>
</tr>
<tr>
<td>the IRB Chair/Designee.</td>
<td>reported to the next convened IRB meeting.</td>
<td>discussion and vote.</td>
</tr>
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</table>

- **Exempt Review**

UAMS requires all human subject research studies meeting, or appearing to meet, one of the Exempt criteria to be submitted through ARIA for review and approval by the IRB Chair/Designee. No Investigator or Department on campus shall have the authority to make this decision other than the IRB Chair/Designee. All research, including that in the Exempt categories, must meet at a minimum the principles outlined in the Belmont Report. The IRB Chair/Designee may require additional protections to meet these principles, including a level of informed consent appropriate to the research or review by the full committee.

Studies receiving an Exempt classification by the IRB Chair/Designee will be required to submit a one page Study Update each year in order to keep the study open. The IRB shall be made aware of any changes in the study scope or design prior to implementation of the changes to insure that the study continues to meet the Exempt Criteria.

FDA allows two categories of clinical investigations to be considered exempt from IRB review. However, the IRB requires review of both categories. The FDA emergency use of a
test article process can be found at IRB Policy and Procedures 18.3 (Emergency Use of a Drug or Biologic) and 18.4 (Emergency Use of an Unapproved Medical Device). The other allowable FDA exempt category is listed below as #6 (Taste and food quality evaluation).

No research involving, or potentially involving, prisoners, as participants may be classified under the Exempt Categories listed below.

**How To Apply For Exemption**

Research that falls into any of the six categories listed below from 45 CFR 46.101 should be submitted in ARIA.

**The IRB Chair/Designee, NOT the Investigator, determines if a study may be considered in the exempt category.**

- **Categories of Exemption (Per 45 CFR 46.101)**

  1. Research conducted in established or commonly accepted educational settings, involving normal educational practices, such as research on regular and special education instructional strategies, or research on the effectiveness of or the comparison among instructional techniques, curricula, or classroom management methods.

     **NOTE:** This category may be applied to research involving children.

     **NOTE:** This category may not be applied to FDA regulated research.

  2. Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, unless:

     a. Information obtained is recorded in such a manner that human subjects can be identified, directly or through identifiers linked to the subjects and

     b. Any disclosure of the human subjects' responses outside the research could reasonably place the subjects at risk of criminal or civil liability or be damaging to the subjects' financial standing, employability, or reputation.

     **NOTE:** The section of this category pertaining to standardized educational tests may be applied to research involving children. This category may also apply to research with children when the investigator observes public behavior but does not participate in that behavior or activity. This section is not applicable to survey or interview research involving children.

     **NOTE:** This category may not be applied to FDA regulated research.
3. Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior that is not exempt under paragraph (b) above, if:

   a. The human subjects are elected or appointed public officials or candidates for public office or

   b. Federal statute(s) require(s) without exception that the confidentiality of the personally identifiable information will be maintained throughout the research and thereafter.

   NOTE: This category may not be applied to FDA regulated research.

4. Research involving the collection or study of existing data documents, records, pathological specimens, or diagnostic specimens, if these sources are publicly available or if the information is recorded by the investigator in such a manner that subjects cannot be identified, directly or through identifiers linked to the subjects.

   a. To qualify for this exemption the data, documents, records, or specimens must be in existence before the project begins. Investigator must describe where the information exists.

   b. Under this exemption, an investigator (with proper institutional authorization) may inspect identifiable records, but may only record information in a non-identifiable manner. Investigator must describe how information will be obtained, what data elements will be recorded, and whether any links to identifiers will be recorded.

   NOTE: Inclusion of fetal tissue in the pathological specimens category of exempt research is prohibited by regulation and requires additional IRB review.

   NOTE: This category may not be applied to FDA regulated research.

5. Research and demonstration projects which are conducted by or subject to the approval of federal Department or Agency heads, and which are designed to study, evaluate, or otherwise examine:

   a. Public benefit or service programs; this exemption is for federally supported projects and is most appropriately invoked with authorization or concurrence by the funding agency. The following criteria must be satisfied to invoke the exemption for research and demonstration projects examining "public benefit or service programs."

      i. The program under study must deliver a public benefit (e.g., financial or medical benefits as provided under the Social Security Act) or service (e.g., social, supportive, or nutrition services as provided under the Older Americans Act)
ii. The research or demonstration project must be conducted pursuant to specific federal statutory authority.

iii. There must be no statutory requirement that an Institutional Review Board review the project.

iv. The project must not involve significant physical invasions or intrusions upon the privacy of participants.

b. Procedures for obtaining benefits or services under those programs;

c. Possible changes in or alternatives to those programs or procedures;

d. Possible changes in methods or levels of payment for benefits or services under those programs.

e. Before invoking this exemption, the IRB will obtain concurrence of the funding agency that this exemption can be applied.

NOTE: This category may not be applied to FDA regulated research.

6. **Taste and food quality evaluation** and consumer acceptance studies if:

a. wholesome foods without additives are consumed or

b. if a food is consumed that contains a food ingredient at or below the level and for a use found to be safe, or agricultural chemical or environmental contaminant at or below the level found to be safe, by the Food and Drug Administration or approved by the Environmental Protection Agency or the Food Safety and Inspection Service of the U.S. Department of Agriculture.

NOTE: This category may be applied to children.

NOTE: This category may be applied to FDA regulated research.

Any research plan that involves both exempt and non-exempt research activities must be reviewed by the IRB.

Procedure:

1. The Investigator will:

   1. Submit a protocol and application through ARIA, including all surveys, questionnaires or other instruments to be used.
   2. Provide any additionally requested information.
3. Submit any proposed or anticipated changes to the IRB, through ARIA Modifications, prior to implementation.
4. On an annual basis, submit an Exempt Study Update Form if desiring to keep study open.

2. The IRB Director or Designee will:

1. Review all requests for exemption.
2. Request additional information as necessary.
3. Document in the Office Notes section of ARIA whether the study appears to qualify for requested category.
4. Draft Approval letter for Chair/Designee signature, or notify Investigator that the study will need to be reviewed by either Expedited or Full procedures.
5. Place on Agenda under Exempt Studies Approved by the Chair/Designee.

3. The IRB Chair/Desigee will:

1. Review submitted documents and Office Notes.
2. Request additional information as necessary.
3. Determine that the research meets the organization’s ethical standards.
4. Determine that the research does not involve prisoners as participants.
5. Determine the category of the exemption and document the category on the Comments section of ARIA.
6. If the research falls into one or more categories of exemption, and meets the organization’s ethical standard, grant a determination that the research is exempt and document that determination on the Comments section of ARIA.
7. If the IRB Chair/Designee cannot grant an exemption, the IRB Chair/Designee should request modifications from the Investigator that would allow the research to be exempt. If the Chair/Designee and Investigator cannot reach agreement the research will be referred to the convened IRB for review.
8. Request approval letter or modification letter be prepared for signature and placement on agenda as Exempt Studies Approved by Chair/Designee.

For more information on the criteria for studies classified as Exempt under the Federal Regulations, see IRB Policy 7.3 (Exempt Categories of Research).
Expedited Review (Per 45 CFR 46.110)

Some types of research do not necessitate review by the convened IRB. These types of studies may be approved by the IRB Chair/Desigee and reported to the convened IRB at its next meeting.

An expedited review consists of a review of research involving human subjects by the appropriate IRB Committee Chair or his/her designee. In reviewing the research, the reviewer may exercise all of the authorities of the full Committee except that the reviewer may not decline the research. Additionally, the reviewer may refer the application to the full Committee for a standard review as warranted.

An Investigator may apply for expedited review, or the IRB Chair/Designee may determine that the study is eligible for expedited review if it meets the regulatory criteria. If the IRB Chair/Designee determines that the project submitted for expedited review requires full committee review, the Investigator will be notified in writing.

The IRB, NOT the Investigator, determines if a study may be considered in the Expedited Review category.

For a new protocol to qualify for Expedited Review, the research must:

1. Present no more than minimal risk to human subjects;

2. Not involve the identification of the subjects and/or responses which would reasonably place them at risk of criminal or civil liability or be damaging to the subjects’ financial standing, employability, insurability, reputation, or be stigmatizing, unless reasonable and appropriate protections will be implemented so that risks related to invasion of privacy and breach of confidentiality are no greater than minimal;

3. Not be classified; and

4. Involve only procedures listed below. Inclusion on the list does not automatically make the research minimal risk. It merely means that the activity is eligible for review provided the circumstances of the specific proposal involve no more than minimal risk to the participants.

Minimal Risk means that the probability and magnitude of harm or discomfort anticipated in the research are not greater in and of themselves than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests.

Categories of Expedited Review for New Protocols

The categories on the list apply regardless of the age of subjects, except as noted.
1. **Clinical studies of drugs and medical devices** only when the conditions below are met.

   a. Research on drugs for which an investigational new drug application is not required. (Note: Research on marketed drugs that significantly increases the risks or decreases the acceptability of the risks associated with the use of the product is not eligible for expedited review.); or

   b. Research on medical devices for which (i) an investigational device exemption application is not required; or (ii) the medical device is cleared or approved for marketing and the medical device is being used in accordance with its cleared/approved labeling.

2. **Collection of blood samples** by finger stick, heel stick, ear stick, or venipuncture as follows:

   a. From healthy, nonpregnant adults who weigh at least 110 pounds. For these subjects, the amounts drawn may not exceed 550 ml in an 8 week period and collection may not occur more frequently than 2 times per week; or

   b. From other adults and children, when the age, weight, and health of the subjects, the collection procedure, the amount of blood to be collected, and the frequency with which it will be collected are considered. For these subjects, the amount drawn may not exceed the lesser of 50 ml or 3 ml per kg in an 8 week period and collection may not occur more frequently than 2 times per week. Children are defined in the federal regulations as "persons who have not attained the legal age for consent to treatments or procedures involved in the research, under the applicable law of the jurisdiction in which the research will be conducted". In Arkansas, this age is 18 years old.

3. **Prospective collection of biological specimens for research purposes by noninvasive means**, for example:

   a. Hair and nail clippings in a nondisfiguring manner;

   b. Deciduous teeth at time of exfoliation or if routine patient care indicates a need for extraction;

   c. Permanent teeth if routine patient care indicates a need for extraction;

   d. Excreta and external secretions (including sweat);

   e. Uncannulated saliva collected either in an unstimulated fashion or stimulated by chewing gumbase or wax or by applying a dilute citric solution to the tongue;

   f. Placenta removed at delivery;

   g. Amniotic fluid obtained at the time of rupture of the membrane prior to or during labor;
h. Supra and subgingival dental plaque and calculus, provided the collection procedure is not more invasive than routine prophylactic scaling of the teeth and the process is accomplished in accordance with accepted prophylactic techniques;

i. Mucosal and skin cells collected by buccal scraping or swab, skin swab, or mouth washings;

j. Sputum collected after saline mist nebulization.

4. **Collection of data through noninvasive procedures** (not involving general anesthesia or sedation) routinely employed in clinical practice, excluding procedures involving x-rays or microwaves. Where medical devices are employed, they must be cleared/approved for marketing. (Studies intended to evaluate the safety and effectiveness of the medical device are not generally eligible for expedited review, including studies of cleared medical devices for new indications.) Examples:

   a. Physical sensors that are applied either to the surface of the body or at a distance and do not involve input of significant amounts of energy into the subject or an invasion of the subject’s privacy;

   b. Weighing or testing sensory acuity;

   c. Magnetic resonance imaging;

   d. Electrocardiography, electroencephalography, thermography, detection of naturally occurring radioactivity, electroretinography, ultrasound, diagnostic infrared imaging, doppler blood flow, and echocardiography;

   e. Moderate exercise, muscular strength testing, body composition assessment, and flexibility testing where appropriate given the age, weight, and health of the individual.

   f. Collection of data from voice, video, digital, or image recordings made for research purposes.

5. **Research involving materials (data, documents, records, or specimens) that have been collected, or will be collected solely for non-research purposes (such as medical treatment or diagnosis).** (NOTE: Some research in this category may be exempt from the requirement that it obtain IRB approval [See IRB Policy 7.3]. (This listing refers only to research that is not exempt.))

6. Collection of data from voice, video, digital, or image recordings made for research purposes.

7. **Research on individual or group characteristics or behavior** (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies.
(NOTE: Some research in this category may be exempt from the requirement that it obtain IRB approval (See IRB policy 7.3 – Exempt Categories of Research). (This listing refers only to research that is not exempt.)

Continuing review of research by the expedited procedure must meet one of the following criteria:

1. Meet the criteria for initial review by an expedited procedure; or

2. Be permanently closed to the enrollment of new subjects, where all subjects have completed all research-related interventions; and the research remains active only for long-term follow up of subjects; or

3. No subjects have been enrolled and no additional risks have been identified; or

4. The remaining research activities are limited to data analysis; or

5. Meet all of the following criteria:

   5.1 Not be conducted under an investigational new drug application or investigational device exemption,

   5.2 Not otherwise qualify for review by the expedited procedure; and

   5.3 The IRB has determined and documented at a full Committee convened meeting that the research involves no greater than minimal risk and no additional risks have been identified.

Modifications can be expedited if the modification is minor. A change is considered minor when it does not materially affect an assessment of the risks and benefits of the study; does not substantially change the aims or design of the study; and is not directly relevant to the determinations required for approval. Examples of items that generally might be considered appropriate for expedited review and approval: Changes in research personnel or contact information, minor changes to the protocol or consent document in order to clarify or correct earlier information provided there is no change in the evaluated risks or potential for benefit.

- Investigator Procedure:

1. For Initial Review of an Expedited Protocol, Investigator must:

   1.1 Submit in ARIA all required new application materials as outlined in IRB Policy 7.4 and select the expedited category s/he believes the study to fit.

2. For Continuing Review under Expedited Procedures:

   2.1 Submit in ARIA a Continuing Review Report noting on the form which criteria for expedited continuing review the project meets.
3. For Modifications to be reviewed under Expedited Procedures:

3.1 Submit in ARIA a Modification form noting in the section entitled “Description of any significant change in the risk/benefit” that the requested modification does not materially affect an assessment of the risks and benefits of the study; does not substantially change the aims or design of the study and is not directly relevant to the determinations required for approval.

- IRB Procedure:

1. For Initial Review of an Expedited Protocol, IRB Chair/Designee must:

   1.1 Review materials in sufficient detail in order to determine that the study meets the criteria for approval as outlined in IRB Policy 7.1.

   1.2 The Chair or designee must determine that the research meets all criteria outlined in section 1 above allowing review by the expedited procedure.

   1.3 Determine that the research does not involve prisoners as participants. If the study involves prisoners, direct the IRB Staff to place the study on the full board section of the agenda for the next meeting in which the Prisoner Representative can attend.

   1.4 Determine the expedited category into which the study fits and document the category on the Comments section of ARIA.

   1.5 If study as designed does not meet any of the expedited categories, the IRB Chair should request modifications from the Investigator that would allow the research to be expedited. If the Chair and Investigator cannot reach agreement the research will be referred to the convened IRB for review.

   1.6 Request approval letter or modification letter be prepared for signature and placement on agenda as Expedited Actions Approved by Chair.

2. For Continuing Review under Expedited Procedures IRB Chair/Designee must:

   2.1 Follow all elements of IRB Policy 7.6 and document that the research meets one of the criteria outlined above in Expedited Review Requirements, Section 3.

3 For Modifications to be reviewed under Expedited Procedures, IRB Chair/Designee must:

   3.1 Determine that the requested modification truly does not materially affect an assessment of the risks and benefits of the study; does not substantially change the aims or design of the study and is not directly relevant to the determinations required for approval.

For more information, see IRB Policy 7.5 (Expedited Review).

The IRB must uphold the standard requirements for informed consent (or its waiver, alteration, or exception) regardless of the type of review (expedited or convened) used.

When performing an expedited review, the reviewer(s) may exercise all of the authorities of the IRB except that they may not disapprove the research. Research may only be disapproved by the convened IRB. IRB Reviewers have access to all information submitted on any project which has received approval or been amended through an expedited review process.
- **Full Review**

  All applications except those qualifying for exempt or expedited status will be reviewed by the IRB at one of its convened meetings. The IRB utilizes primary review teams in conducting full reviews. A minimum of two reviewers will receive the full study protocol application. All committee members will have access to the IRB application forms, protocol summary, and informed consent documents. The Primary Reviewers will present the protocol and issues to the convened IRB for discussion before a vote for approval can be cast.

  A quorum (51% of the specific committee’s voting membership including the chair) of members, including at least one non-scientific member, must be present for voting purposes on each review. After the vote, the Investigator will be notified in writing regarding the status of the application.

- **IRB Review Results**

  The IRB will review research protocols and approve, disapprove, or require modifications before approval is granted. Investigators are notified in writing concerning all IRB actions.

  If the IRB disapproves a study, it will notify the Investigator of the reasons for the disapproval, and allow the Investigator an opportunity to respond. The Investigator may appeal to the IRB to reverse the decision to disapprove a study, but no other authority may approve a study if the IRB disapproves it.

  IRB Review results of new protocols fall into the following categories:

  - **Protocol Approved:**
    The project and its study tools, including the informed consent documents, are approved as submitted. Once the Investigator receives the IRB approval letter, the study may begin.

  - **Protocol Approval Deferred (Major or Minor):**
    The project requires revisions, which the IRB can list as part of the motion. The PI will be provided with comments explaining rationale for the decision and given an opportunity to respond. If Major, these must be addressed and re-reviewed by the convened IRB before the IRB can grant approval. The response will be reviewed by the convened IRB. If deemed Minor, these revisions may be reviewed through the expedited process.

  - **Protocol Tabled:**
    The project has serious deficiencies in submitted protocol. These must be addressed and re-reviewed by the convened IRB before the IRB can grant approval. The PI will be provided with comments explaining rationale for the decision and given an opportunity to respond. The response will be reviewed by the convened IRB. PIs should be aware that the IRB upon receiving the responses to a tabled motion may have additional requested revisions.

  - **Protocol Declined:**
    The project has serious deficiencies in submitted protocol that affecting the safety and welfare of the projected subject population. These must be addressed in a new protocol and be reviewed by the convened IRB before the IRB can grant approval. The PI will be provided with comments explaining rationale for the decision and given an opportunity to respond. The response will be reviewed by the convened IRB.
Any involvement of human subjects in research may not begin until the approval of the IRB has been received.

_notification_of_investigators_following_review_

The IRB office, through ARIA, notifies each Investigator of the review of their initial protocol submission, correspondence received by the IRB office, protocol activities reported at the IRB meeting, and continuing review process. The notification should be issued within 14 business days and outline the IRB actions and any further issues which must be addressed by the principal Investigator. Upon receipt of that notification the PI, or designee, should make the required corrections, modifications, or resubmission of a new protocol through ARIA.

All correspondence with the IRB must be submitted in ARIA under the IRB number or reference the IRB Record number. Correspondence that does not identify the IRB number may be returned without further action.

_notification_of_institutional_officials_

The minutes of the IRB meetings reflect summarized discussion of protocol issues and documentation of the vote on each IRB action. Upon request, a copy of the IRB minutes will be sent to the Vice-Chancellor for Academic Affairs and Sponsored Research.
Guidelines for Blood Draws in Pediatric and Adult Populations

Note: For requests greater than the maximum draw, please contact the attending physician for approval of additional amounts for inpatients and the laboratory pathologist for additional amounts for outpatients.

Maximum Allowable Blood Draw Volumes Chart Based on Body Weight in Kilograms (Revised 09/2002)

<table>
<thead>
<tr>
<th>Body Weight In Kg</th>
<th>Maximum Drawn In One Blood Draw</th>
<th>Maximum Drawn In A 30 Day Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Kg</td>
<td>2.5 ml</td>
<td>23 ml</td>
</tr>
<tr>
<td>2 Kg</td>
<td>4.5 ml</td>
<td>23 ml</td>
</tr>
<tr>
<td>3 Kg</td>
<td>6 ml</td>
<td>23 ml</td>
</tr>
<tr>
<td>4 Kg</td>
<td>8 ml</td>
<td>30 ml</td>
</tr>
<tr>
<td>5 Kg</td>
<td>10 ml</td>
<td>40 ml</td>
</tr>
<tr>
<td>6 Kg</td>
<td>12 ml</td>
<td>40 ml</td>
</tr>
<tr>
<td>7 Kg</td>
<td>14 ml</td>
<td>40 ml</td>
</tr>
<tr>
<td>8 Kg</td>
<td>16 ml</td>
<td>60 ml</td>
</tr>
<tr>
<td>9 Kg</td>
<td>18 ml</td>
<td>60 ml</td>
</tr>
<tr>
<td>10 Kg</td>
<td>20 ml</td>
<td>70 ml</td>
</tr>
<tr>
<td>11 thru 15 Kg</td>
<td>22-30 ml</td>
<td>70-100 ml</td>
</tr>
<tr>
<td>16 thru 20 Kg</td>
<td>32-40 ml</td>
<td>130-140 ml</td>
</tr>
<tr>
<td>21 thru 25 Kg</td>
<td>42-50 ml</td>
<td>160-180 ml</td>
</tr>
<tr>
<td>26 thru 30 Kg</td>
<td>52-60 ml</td>
<td>200-220 ml</td>
</tr>
<tr>
<td>31 thru 35 Kg</td>
<td>62-70 ml</td>
<td>240-250 ml</td>
</tr>
<tr>
<td>36 thru 40 Kg</td>
<td>72-80 ml</td>
<td>270-290 ml</td>
</tr>
<tr>
<td>41 thru 45 Kg</td>
<td>82-90 ml</td>
<td>290-330 ml</td>
</tr>
<tr>
<td>46 thru 50 Kg</td>
<td>92-100 ml</td>
<td>330-350 ml</td>
</tr>
<tr>
<td>Greater than 51 Kg</td>
<td>100 ml</td>
<td>350 ml</td>
</tr>
</tbody>
</table>

Reference: 2.2 lb = 1 Kg

This information, for single draw, is similar to that recommended by the Committee on Clinical Investigations at Children’s Hospital in Los Angeles, and also used at Baylor College of Medicine in Dallas, Texas, and at Children’s Hospital and Regional Medical Center Laboratory in Seattle, Washington. The maximum draw volumes for a 30-day period are similar to those recommended by Becan-McBride, Phlebotomy Handbook (5th edition).

Adapted by Paula North, M.D., Ph.D., August 2002, Arkansas Children’s Hospital, Little Rock, Arkansas. Approved by ACH Patient Care Committee September 2002.
CHAPTER 4

Protocol Submissions

This chapter instructs Investigators how to submit new protocols.

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Prior To Submission

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- Designating The Principal Investigator
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- General Clinical Research Center (GCRC)
- Grants and Funding Sources
• Pharmacy
• VA R & D Committee
• Institutional Biosafety Committee
• Conflicts of Interest Committee

Using Investigational New Drugs

Using Investigational New Devices

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Collaborating With Other Institutions

Data Safety Monitoring Information

Application Forms and Original Signatures

IRB Protocol Submissions Requirements Using ARIA

How To Submit A New Study Protocol Using ARIA
Investigator Requirements

In order to best protect those participating in research, Investigators should have the necessary training and background to conduct studies in accordance with the protocol, organizational policies and procedures, applicable regulations, such as those concerning IRB review, informed consent requirements, reporting requirements, maintenance of records, retention of records, and supervision of research conduct.

Before undertaking a project, an investigator needs to determine if s/he has the time, equipment and necessary staff in terms of numbers and/or qualification in order to conduct the research in a way that will protect participants.

For more information on Investigator qualification and requirements, see IRB Policy 7.2 (Investigator Qualifications).

Prior To Submission

Prior to preparing a research application, Investigators should consider the following:

- Does the project involve research, as defined below?
- Will the project involve living human subjects or their identifiable information?

Definition Of Research

Research is a systematic investigation, including research development, testing, and evaluation designed to develop or contribute to generalized knowledge [45CFR46.102(d)]. Examples of research activity include clinical investigations, clinical trials, surveys, interviews, behavioral investigations, retrospective reviews of medical information, experiments with blood and tissue, and demonstration or service programs.

Responsibilities Of The Principal Investigator When Submitting A Study For IRB Approval

The Principal Investigator (PI) has the responsibility of submitting his/her proposed research for approval prior to accessing any information or to any human subject enrollment. The PI must assure that all persons performing research activities under his/her direction are properly credentialed by the institution to perform the procedures or interventions outlined in the research protocol.

Approval by the IRB does not relieve the PI from the obligation to follow procedures and rules of the institution(s) at which the research is to be undertaken.

Each PI is responsible for providing assurance to the IRB that activity on the approved protocol is continuous. Investigators must also maintain continuous approval from each institution(s) where the research is being conducted. The study must be reviewed and re-approved by IRB not less than one year from the date of study approval. If this continuing review report (CRR) is not approved by the date specified, the study no longer has approval and a letter of study suspension will be issued. No new subjects may be enrolled until approval of the CRR is obtained from the IRB and all interactions with currently enrolled subjects must cease unless for subject safety the IRB specifically approves continued interaction. If the PI does not respond to subsequent IRB request for
continuing review reports, the study will be terminated. Patterns of noncompliance by the
Investigator can trigger formal inquiries by the IRB.

The validity of the CRR information must be supported in the study records. The PI has the
responsibility to monitor study records for completeness, accuracy, authenticity, and validity.

The PI (or his/her formally authorized designee) must sign ALL communication
with the IRB. The IRB must approve the alternate or formally authorized signatory.
Communication not signed by the appropriate person will be returned.

- Study Closure Information

At the conclusion of any study, the PI must submit a Study Closure form to the IRB through
ARIA, including applicable data analysis and long-term follow-up, so that the study can be
closed. The final report of study results should be received by the IRB within 30 days of
decision to close a study. Investigators may request closure of a study upon continuing
review or by submitting a separate study closure form. When a protocol is complete except
for data analysis or long-term follow-up, the PI should indicate the status of the protocol on
the CRR so that approval can be expedited. Studies are not to be closed until the
Investigator has determined that the study no longer needs access to any identifiable
information.

- The PI is responsible for abiding by the Investigator’s Agreement that includes the
  following items:

  - No subjects will be recruited or entered into a protocol until the Investigator has received an
    approval letter from the IRB.
  - No modification of the protocol or consent form will be initiated without prior written
    approval from the IRB, except when necessary to eliminate immediate hazards to the
    subjects. Exceptions for immediate hazards must be reported orally to the IRB Chair or
    Designee immediately.
  - The PI will provide a prompt, written report to the IRB regarding any deviation from the
    protocol and/or consent form, adverse events that are serious, unexpected and related to the
    study, or a death occurring during the study.
  - Annual status reports for the protocol (CRR) will be completed and returned within the time
    limit stated on the forms.
  - If the study involves any funding or resources (such as drugs or devices) from outside
    sources, the Grants Coordinator in the appropriate Institutional Research Administration
    Office must be contacted regarding a contract. Subjects cannot be enrolled prior to
    completion of the contract, unless specified by the institution.
• If the study involves industry sponsored trials at the VA, the PI must contact the Biomedical Research Foundation

• Informed consent will be obtained from all subjects using the method approved by the IRB for the research protocol, unless waived by the IRB.

• The IRB office will be notified within 30 days of a change in the PI.

• The PI will sign via ARIA a statement regarding the protection of human subjects and vulnerable populations.

Failure to abide by the approved research plan can lead to suspension or termination of studies or to suspension of the PI's research privileges by the IRB.

❖ Planning The IRB Submission

❖ Mandatory Education

As of January 31, 2004, all research staff involved with human subject studies must have completed the on-line Human Subject Training (HST) course and the on-line HIPAA for Research course.

Two different on-line HST courses are offered: the Biomedical Course on Human Subject Protection Training and the Behavioral and Social Science Course on Human Subject Protection Training. Only one HST course is required, and the research staff should select the one most appropriate to the type of research in which they will be involved.

The Biomedical Course is appropriate for persons whose research involves drugs, devices, and surgical/invasive procedures. The Behavioral and Social Science course is relevant to those disciplines and is not appropriate for Investigators whose research involves drugs, devices or surgical/invasive procedures. Both courses integrate UAMS IRB requirements.

All three of these on-line courses are found by selecting the Training button on the Office of Research Compliance website at www.uams.edu/orc. Then select “Online Course Registration”. You will be asked to type in some demographic information. This will register you for the appropriate courses through WebCT.

The HIPAA for Research course is in additional to any general HIPAA course that may be required by an Institution for all of its employees.

❖ Study Design

Investigators should understand that the human research must be conducted using a research plan or “protocol” that has been submitted and approved by the IRB. Grant applications may not be submitted in lieu of a protocol. All changes in the protocol must be approved by the IRB before implementing, unless the change is urgently required for the subject’s safety. The PI must contact the IRB Chair immediately if such urgent safety conditions will alter the protocol or consent.
Investigators must submit a clinical research protocol detailing all aspects of the proposed human studies. This document is distinctly different than the grant application for funding the proposed project in that it provides the IRB with details of how all phases of the human studies will be conducted. Investigators must also submit the research portion of any grant proposal for which IRB approval is sought, however the IRB does not accept a grant proposal in lieu of a detailed description of how all human studies are to be accomplished.

Plans for human research should reflect appropriate consideration on the part of the Investigator of all aspects of the proposed research. Specifically, the questions that the PI proposes to answer and the precise methodology needed to obtain those answers must be included in the research plan.

- **Designating The Principal Investigator**

  A research project is headed by a Principal Investigator (PI). The PI leads the research team, directs the project, and bears ultimate responsibility for its conduct.

  The IRB must ensure that the PI has the requisite training and experience that the project requires. Documented HST and HIPAA for Research training is required of the PI, Investigators and the research team.

  Whenever there is a change in the PI or in the PI's status that affects the project, the IRB must be notified.

- **Sub-Investigators**

  If the study requires collaboration from another area, a Sub-Investigator from that area can be designated. The Sub-Investigator should be consulted and familiarized with his/her responsibilities. A copy of the Sub-Investigator’s curriculum vitae or resume and license (if appropriate) should be included in the study submission. If an FDA form 1572 is required for the study, it must be kept updated if there is a change in Sub-Investigators.

  Cooperative groups, such as COG (Children’s Oncology Group) or SWOG (Southwest Oncology Group) does not allow non-members, including residents and students, to conduct research.

- **Student Conducted Research**

  All activities that meet the definition of research with human subjects and that are conducted by students for a class project or for work toward a degree must be reviewed by the IRB. Resident physicians are considered students. For example, activities that must be reviewed and approved by the IRB include:
a. All master’s theses and doctoral dissertations that meet the definition of research and involve human subjects or their data; and

b. All projects that involve human subjects or their data and for which findings may be published or otherwise disseminated.

**Oversight by Faculty/Advisor.** All students/fellows residents in UAMS applying as PI on a study for IRB review must list their faculty advisor as a Co-Investigator. The faculty member should be listed as PI if there is contemplation of continuing the student’s work following their matriculation.

**Specifying The Number Of Research Subjects**

The IRB is required to protect subjects from the first contact for possible recruitment. All subjects who go through the recruitment process even if they fail screening or decline participation at a later date must be accounted for. Thus, total accrual is the number of subjects go through the consent process. Initial requests for subject accrual should be large enough to reflect accurate accrual goals plus any screen failures and anticipated drop-out rates.

The application must specify the number of study subjects to be accrued, grouped by age, gender, and population diversity. Exceeding the accrual limits approved by the IRB is a violation of the protocol. The IRB must give prior written approval for any increase in subject accrual.

Multi-center studies, in which data will be pooled and recruitment may vary, present a special problem for Investigators. The application should provide information about the total picture, including both the number of subjects to be studied locally and the number studied at all sites.

**Women And Minorities In Study Populations**

The study plan should be designed so that research benefits and burdens are fairly distributed. If an individual or group is denied access to a clinical trial that might be beneficial or if some people are singled out to bear the burden of risks associated with a study, the requirement for fairness is not met.

In accordance with the policies of the National Institutes of Health, the IRB requires researchers applying for federal funds to give breakdowns of their subject populations by gender and minority group. Studies with the potential to address issues relevant to both sexes must recruit both genders, and minority populations should be included in a study population wherever feasible. Researchers must justify the exclusion of any group of individuals. The IRB may make exceptions if there is adequate scientific justification for exclusion, such as when a disease predominates in one gender or the focus of the research question is on a specific group.

**Students As Research Subjects**

When students are to be accrued for research, consent must state that students are allowed to refuse participation or withdraw early from a study without affecting their academic standing at UAMS. Prohibiting all student participation in research, however, may be an overprotective reaction. An alternative way to protect against coercion is to require that Faculty-Investigators advertise for subjects generally (e.g., through notices posted in the school or department) rather than recruit...
individual students directly. As with any research involving a potentially vulnerable subject population, the IRB will pay special attention to the potential for coercion or undue influence and consider ways in which the possibility of exploitation can be reduced or eliminated.

Confidentiality is a concern raised by the involvement of students as subjects in research. The IRB will consider that research involving the collection of data on sensitive subjects such as mental health, sexual activity, or the use of illicit drugs or alcohol presents risks to subjects of which they should be made aware and from which they should be protected, to the greatest extent possible. The close environment of the university amplifies this problem.

For more information, see Chapter 12, Research Involving Vulnerable Populations and IRB Policy 17.10 (Students, Employees and Healthy Volunteers).

Employees As Research Subjects

The issues with respect to employees as research subjects are essentially identical to those involving students as research subjects: coercion or undue influence, and confidentiality. Employee research programs raise the possibility that the decision will affect performance evaluations or job advancement. Maintaining the confidentiality of personal medical information or research data when the subjects are also employees, particularly when the employer is also a medical institution [Meyers (1979)] is difficult. For issues regarding compensation each affiliated institution may have policies that apply. The Investigator is responsible for following those policies.

For more information, see Chapter 12, Research Involving Vulnerable Populations and IRB Policy 17.10 (Students, Employees and Healthy Volunteers).

Research Informed Consent

Informed Consent is an ongoing process. The research informed consent process should be detailed in the submission process. All consent documents must be written according to federal regulations and IRB requirements and should be consistent with study protocols. All informed consent documents must be approved by the IRB. For more information on the Informed Consent process, see Chapter 5, Informed Consent.

HIPAA

According to the UAMS Administrative Guide, the scope of the HIPAA Research Policy (Research alone OR combined with treatment) applies to all UAMS physicians, faculty, employees and students performing research on human subjects (living or deceased) or their data, or conducting review of Protected Health Information (PHI) preparatory to research. For research conducted in a non-UAMS physical location, such as Arkansas Children’s Hospital, the policies of that institution will apply.

UAMS policy is to protect the privacy and confidentiality of medical records and information contained in the medical records of persons who are subjects of UAMS Research projects, including any and all Protected Health Information as defined by the HIPAA Privacy Regulations. Protected Health Information of a Research subject, and the use or disclosure of such information, shall be governed by the UAMS Research policy and any other applicable UAMS policies.
This HIPAA Research Policy does not replace the legal requirements or UAMS policies concerning compliance with the Common Rule, FDA regulations, or other applicable laws.

 Approval Bodies And Committees

Approval or clearance from various bodies located in all of the institutions where the research will occur is required prior to beginning your study. The Investigator will present appropriate letters of approval with the protocol submission to the IRB for review or as soon thereafter as possible.

If you plan to conduct your study at more than one institution that uses the UAMS IRB as its IRB of record, an approval letter or a copy of the application letter for each institution’s appropriate committee (i.e., VA R&D, PRMC, radiation safety, biosafety, etc.) will be required prior to starting your research project. The PI remains responsible for ensuring that all of the appropriate committee approvals are in place prior to conducting the research. **Do not start any research until all approval letters have been received.**

The UAMS IRBs functions independently of (but coordinates its activities with) other committees and departments at UAMS, CAVHS, ACH and ACHRI. The IRBs will work in conjunction with other university or institutional committees; however, it will review research projects independently to ensure that human participants will be adequately protected. For more information, see [IRB Policy 2.2 (To Other University or Affiliated Committees/Departments)](#).

- **Other IRBs**

  In order for the UAMS IRB to rely on another IRB for any review, it must be AAHRPP accredited.

  The investigator MUST inform the IRB of all sites and FWAs of those sites where the study will take place and any other IRBs and FWAs of those IRBs that will be involved.

Questions about this should be referred to the IRB assistant director or via email at irb@uams.edu. For more information, see [IRB Policy 2.3 (To Other Institutions)](#).

The number and composition of IRB Committees at UAMS may vary at times to support the volume and type of human research to be reviewed in a thorough and timely manner. Composition of the individual committees will in general be along the discipline lines of biomedical and behavioral and social sciences. Committees with a different focus may be added if warranted to meet the needs of the research program.

A contact list for these committees and other resources at the various institutions covered by the IRB is listed in the [Resource List of Committees and Institutional Contacts](#).

- **ACH/ACHRI**

  Research at Arkansas Children’s Hospital requires approval by the Arkansas Children’s Hospital’s Research Institute (ACHRI). For more information, contact the Legal and Human Protections Administrator, at 501-364-3571.
**Ionizing Radiation**

If the study includes ionizing radiation, it is the Investigator’s responsibility to obtain approval from the Radiation Safety Committee in each institution where the research will be performed if approval is required. For more information on the UAMS Radiation Safety Committee, contact the Radiation Safety Officer at 501-686-5299 or visit the [UAMS Radiation Safety Committee website](#).

**Example:**

You plan to conduct a pulmonary study involving frequent chest x-rays and computerized tomography (CT) scans on subjects admitted to the VA and UAMS hospitals. An approval letter from or letter of application to each institution’s radiation safety committee will be required with your submission to the IRB.

**Oncology Research**

If the study involves oncology, the protocol may need to be submitted to the ACRC Protocol Review and Monitoring Committee (PRMC). This applies to both UAMS and CAVHS oncology protocols. The PRMC reviews all cancer protocols conducted under the auspices of the Arkansas Cancer Research Center for scientific merit, subject availability, and available resources. The PI is responsible for submitting oncology protocols to the PRMC for approval in addition to IRB approval. Clinical protocols that are NOT cancer-related, but have an ACRC member as a principal Investigator do not require PRMC approval.

**Recombinant DNA and/or biohazardous protocols**

Projects that require UAMS Biosafety Committee (IBC) approval before protocol submission to IRB include:

- Protocols involving NIH/CDC designated “select agents.”
- Experimentation using BL2 or BL3 infectious microorganisms
- Experimentation using carcinogenic (known or suspected) or highly toxic compounds.
- Recombinant DNA, if BL2 or BL3 organisms are involved or if genetic modification might increase pathogenicity, transmissibility, host range, or antibiotic resistance of a pathogen.
- The transfer of toxin genes lethal for vertebrates at an LD50 <100ng/kg.
- Modification of the germ-line genes of animals (transgenic)
- Human gene therapies even if recombinant DNA is produced elsewhere.
The UAMS Biosafety Committee completes its review of protocols as soon as possible after they are received. If the proposal involves the CAVHS, contact the VA research Office to submit to the VA Research Safety Committee. A list of contact numbers for the institutional subcommittees can be found in the Resource List of Committees and Institutional Contacts.

- **General Clinical Research Center (GCRC)**

The GCRC is a National Institutes of Health (NIH) funded grant primarily intended to leverage federal funding for Investigator-initiated, human-based research and serves the research communities of UAMS, CAVHS and ACH. The GCRC provides Investigators with specialized research space, dedicated research nursing support, dietary consultation and metabolic kitchen, biostatistical support, informatics consultation, design and maintenance, and specialized core laboratories.

Protocols are reviewed by the GCRC Advisory Committee (GAC) and must be received by the second Friday of each month for review on the first Friday of each subsequent month. In addition to GAC approval, each protocol must gain both IRB approval and VA R&D Committee approval prior to initiation on the GCRC. For more information, please access the GCRC website at www.uams.edu/gcrc or call 501-257-5890.

- **Grants and Funding Sources**

Studies done at UAMS must be submitted to the Office of Research and Sponsored Programs (ORSP). Studies conducted at CAVHS must also be submitted to the Biomedical Research Foundation. At ACH, the studies are to be submitted to the Arkansas Children’s Hospital Research Institute. Funds are usually not released until IRB approval and institutional approval is obtained.

If a research study is grant initiated, it has to be first sent to the respective Research and Sponsored Programs Office. Grants cannot be awarded until all approval letters are submitted. For example, if a research study is funded by a NIH grant, the PI has to submit the study to the NIH first then submit it to the IRB. These submissions can occur simultaneously.

- **Pharmacy**

If the proposed research involves the use of a pharmaceutical, the pharmacy in each institution where the research will take place must be consulted. ACH, CAVHS, and UAMS all have policies requiring dispensing of all investigational drugs through their pharmacies. All pharmacies require Cost Impact Information forms to be completed.

The receipt, storage, and dispensing of drug will be overseen by each institution's pharmacy. Each pharmacy requires information about the protocol and a copy of each subject's informed consent documents. A list of Pharmacy Contacts is located in the Resource List of Committees and Institutional Contacts.
**VA R & D Committee**

Research at Central Arkansas Veterans Healthcare System (CAVHS) requires approval by the VA Research and Development Committee (VA R&D). If you answer 'yes' to any of the following three statements, your study must be approved by the VA R&D before the study can begin: (1) The study involves VA patients or seeks to recruit from the VA patient population; (2) the study is funded by the VA; or (3) the study involves VA property (this includes a scenario in which the PI has office space on VA property or is using the GCRC). You will find submission instructions at [www.lrva-research.uams.edu](http://www.lrva-research.uams.edu). Additionally you may contact the Administrative Office for Research at 501-257-4816.

You may submit proposals simultaneously to the IRB and VA R&D. The VA R&D may approve a proposal 'pending IRB approval'. In these situations, once confirmation of IRB approval is received, the VA R&D will complete the 'final approval letter'.

Investigators conducting protocols with human subjects at CAVHS must complete additional required VA training in the mandatory instruction on human subject protections. Instructions for this training are found on the website indicated above.

**Institutional Biosafety Committee**

Research involving the direct and deliberate transfer of biologically derived products listed below into human participants must receive approval from the appropriate Biosafety Committee before final IRB approval may be granted. The IRB may grant final approval pending approval of the Institution’s Biosafety Committee. The IRB Chair or experienced IRB member designated by the Chair will review the approval of the Institution’s Biosafety Committee. If the approval raises issues or questions that are directly relevant to the determinations required by the IRB, or request more than minor changes to the research approved by the IRB, the information or changes will be placed on the agenda of a convened IRB meeting for review. Otherwise, the IRB Chair or experienced IRB member designated by the Chair may grant final approval under expedited procedures.

- Experimentation using BL2 or BL3 infectious microorganisms.
- Experimentation using carcinogenic (known or suspected) or highly toxic compounds.
- Recombinant DNA, if BL2 or BL3 organisms are involved or if genetic modification might increase pathogenicity, transmissibility, host range or antibiotic resistance of a pathogen. The transfer of toxin genes lethal for vertebrates at an LD_{50} of <100 ng/kg.
- Modification of the germline genes of animals (transgenic).
- Human gene therapy even if the recombinant DNA is produced elsewhere.
Conflicts of Interest Committee

Research involving any actual or perceived conflicts of interest as per institutional policies. The IRB will not review research with a declared financial interest until the Conflicts of Interest Committee has completed its evaluation and any management. The written determination of the Conflicts of Interest Committee, and the reasons for those determinations will be provided to all IRB members for review at a convened meeting. ORSP maintains all the annual disclosures of conflicts of interest and the proposed management plan and will upon request provide the annual conflict of interest disclosure forms to the IRB Director, IRB Chair or their Designee. The IRB Director/Chair/Designee shall have access to conflict disclosures which may assist in forming the basis to ascertain the level of conflict or changes in conflict using the following criteria: If the financial conflict of interest management plan affects the IRB approval criteria, the IRB will not approve the project. The IRB may require the consent to reveal any conflict and management plan, even if the approval criteria are not affected.

For more information about the different institutional committees, see IRB Policy 2.2 (To Other University or Affiliated Committees/Departments).

Using Investigational New Drugs

For information on using investigational new drugs in research studies, see Chapter 11, Investigational Drugs and Medical Devices.

Using Investigational New Devices

For information on using investigational new devices in research studies, see Chapter 11, Investigational Drugs and Medical Devices.

Advertising For Subject Recruitment

Studies may require the use of print, television, Internet or radio advertisement in order to accrue the subject population. Advertisements used for recruitment of subjects to participate in research protocols must be submitted to and approved by the IRB prior to use. Any type of advertising for research subjects that is intended to be seen or heard by possible subjects is considered to be part of subject selection process. The IRB must review both the information contained in the advertisement and the mode of its communications.

Information placed on a website for the purposes of study recruitment must receive prior approval from the IRB.

Advertisements should not be coercive and should not state or imply a certainty of favorable outcome or other benefits beyond what is outlined in the consent document and the protocol. No claims should be made, either explicitly or implicitly, that the drug, biologic or device is safe or effective for the purposes under investigation, or that the test article is known to be equivalent or superior to any other drug, biologic or device. Such representation would not only be misleading to potential participants but would also be a violation of the FDA regulations concerning the promotion of investigational drugs and investigational devices.
Advertising should not use the terms “New Treatment,” “New Medication,” or “New Drug” but rather the term “Investigational.”

**Advertisements should not** promise "free medical treatment," when the intent is only to say participants will not be charged for taking part in the investigation. The IRB will determine if the promise of treatment without charge is coercive to financially constrained participants. Advertisement may state that participants will be paid, but should not emphasize the payment or the amount to be paid.

Advertisements must include
- The name and address of Clinical Investigator and/or research facility
- The condition under study and/or the purpose of the research
- In summary form, the criteria that will be used to determine eligibility for the study
- A brief list of participation benefits, if any (*e.g.*, a no cost health examination)
- The time or other commitment required of the participants
- The location of the research and the person or office to contact for further information.

**Collaborating With Other Institutions**

Collaboration with other institutions may be conducted at various levels. The IRB should be notified of the level of collaboration in order to ensure appropriate procedures are instituted. Questions regarding collaboration with other institutions may be emailed to: irb@uams.edu

If Institutional Review Board (IRB) review is required at each collaborating institution, there are options to providing required review as *per* Federal regulations. If the collaborating institution has a federally approved IRB, that IRB will review the study unless they request that the UAMS IRB be the IRB of record. If a collaborating institution chooses for the UAMS IRB to be their IRB of record, additional agreements must be entered into between the two institutions.

If a research project at UAMS is to be carried out in conjunction with another institution or entity and the UAMS IRB will be responsible for the review of the project, the IRB incurs certain aspects of liability that require additional information from the Investigator. An IRB Authorization Agreement and a Federalwide Assurance (FWA) may also be necessary from the cooperating institution. A FWA is a document which formalizes an institution's commitment to protect human subjects and is required by any institution that participates in Federally supported human subject research. The UAMS Investigator should provide the UAMS IRB office contact information for the person at the collaborating institution with whom UAMS can work with to ensure that the appropriate agreements are in place for the collaborative research project.

The local IRB must approve all research studies conducted by CAVHS participants through the CAVHS Cooperative Studies program with other VA hospitals across the country.

Once all committee approvals (or submissions), grants and budgets information (this does not need to be finalized, just in process if applicable), and appropriate education certification has been documented, the PI can assemble the documents required for IRB review. While planning for the IRB review, it is a good time to prepare your submissions for the other institutional research bodies where the trial will be conducted.
Data Safety Monitoring Information

The UAMS IRB requires that each new research application except those qualifying as “Exempt” will include a plan to assure the safety and welfare of its participants. The IRB (Full, Chair or Designee depending on nature of research) will review and approve these plans. The IRB will be the final arbiter of the type of plan needed.

The Principal Investigator may need to appoint a Data and Safety Monitor (DSM) or Data and Safety Monitoring Board (DSMB) for his or her study as appropriate for the size, complexity, and level of risk involved in the research.

Data Safety Monitoring Plan.

Some studies do not require a DSM or a DSMB. However, a detailed DSMP is required for all research that is not “Exempt” under Federal regulations. The level of detail in the plan should be based on the degree of risk entailed by the research participants. All DSMPs must contain at a minimum the following:

a. A description of how risks are minimized;
b. A description of how risks are reasonable in relation to anticipated benefits;
c. Identification of a DSM or DSMB;
d. A description of the general data safety monitoring plan;
e. A description of the plan to monitor progress and safety;
   i. This may include a plan for safety review either by an assigned board, committee or monitor at predetermined intervals relevant to the complexity of the research;
   ii. Depending on the complexity of the research, the plan may include assessments of data quality, timeliness, participant recruitment, accrual and retention.
f. A description of the plan to assure compliance with reporting of adverse events and/or unanticipated problems involving risk to participants or others. This may include:
   i. A description of the process for detecting and reporting serious and unexpected adverse events and/or unanticipated problems involving risk to participants or others;
   ii. A description of who will be monitoring and collecting the adverse events (e.g., PI, Research Nurse, etc.);
   iii. Specification of who will be notified of an adverse event (e.g., IRB, NIH, FDA, PI, etc.)
   iv. A reporting plan indicating the timing of reports;
   v. A plan for annual reporting of adverse events if study longer than one year;
g. A description of the plan to assure suspensions of funded trials are reported to the grants program director; and
h. A description of the plan to assure data accuracy and protocol compliance.

For more information, see IRB Policy 7.8 (IRB Oversight of Activities for Data Safety Monitoring).
Application Forms and Original Signatures

The PI must sign ALL communication with the IRB. Communication not signed by the PI will be returned.

IRB Protocol Submissions Requirements Using ARIA

The PI must submit their entire protocol to the IRB for review using ARIA (Automated Research Information Administrator).

For assistance with obtaining an ARIA username and password or for assistance with submitting protocol using ARIA, please contact the IRB office at 501-686-5667.

The documents required for IRB Protocol Submissions have to be uploaded in ARIA or you CANNOT submit. All documents need to be in a PDF Format. If you will be submitting protocols, you will need to purchase a copy of the software Adobe Acrobat.

NOTE: The latest copies of Adobe Acrobat and Adobe Approval are now available through UAMS IT Procurement for UAMS tagged PCs. To obtain more information or a copy of the software, please contact the Help Desk at (501) 686-8555.

- Information From The Following Documents Is Needed For Protocol Submissions Via ARIA:
  - HIPAA Authorization forms or Request a Waiver of HIPAA Authorization
  - A copy of the consent form (see Chapter 5 – Informed Consent and the Informed Consent Checklist on the IRB website) If a DHHS approved sample consent exists, provide it as well and justification for any substantial deviations.
  - A complete protocol containing details of the proposed research project, including:
    - Study background including scientific rationale and aims
    - Methods
    - A list of all procedures which are experimental
    - Anticipated risks and benefits to subjects and procedures to minimize risks
    - A discussion of human subject protection issues and methods
    - Number of subjects
    - Additional safeguards for the protection of vulnerable subject populations
    - Applicable confidentiality issues
    - Data analysis method
• References

• A copy of the investigational drug or device brochure (from the sponsor) if the protocol requires the use of an investigational drug or device.

• A copy of the study Standard Operating Procedures (SOPs) if used in conducting the study.

• If the study is being done at the CAVHS, a copy of the VA forms you plan to submit there.

• If the study is being done at ACH, the review of protocol letter from Arkansas Children’s Hospital Research Institute (ACHRI).

• A copy of any survey or questionnaire to be used in the research.

• A copy of any advertisement to be used for subject recruitment.

• A simplified CV of the PI.

• Letters from appropriate committees, (i.e. Radiation Safety, PRMC, Biosafety Committees).

• If the study is funded by a grant, a copy of the entire grant application is required.
How To Submit A New Study Protocol Using ARIA

1. Access the ARIA website https://aria.uams.edu/default.lasso
2. Select PI LOGIN.
3. Enter your Username and Password.
4. Click on the Login button.
5. The “Welcome To ARIA” page appears.
6. Select Profile and edit the information if needed.
7. Click the Continue button to return to the main menu.
8. Select New Submission.
9. Select a Protocol Type:
   Is this a Behavioral, or Biomedical Study? Be sure to select the appropriate study type.
10. Click the Continue button.
    Complete the steps that follow by providing the requested information.
11. After all questions have been answered you will be able to “Add New Documents”. All documents MUST be PDFs.
12. Type in Title of Document, Type in Version #, Date.
13. Click the Add Document button.
14. Click the Add File button.
15. Select File.
16. Click the Browse button to find file on your computer.
17. Click the Upload File button.
18. Is this document acceptable? Yes or no
19. Click Yes.
20. Add all documents that are needed for this New Submission.
21. When you are finished adding documents, click the Continue button. Errors in the application will be identified and must be corrected to proceed.
22. Read the Investigator’s Agreement.
23. Click on the “I AGREE” button. It becomes an electronic signature.

You will receive an email acknowledgement that the IRB has received the online submission form.
CHAPTER 5

Informed Consent

Since the central requirement for human subjects research is that people participate voluntarily, the informed consent process is one of the most important parts of planning a research proposal. The process must assure that the potential subject understands the study and its risks and benefits and can certify his or her willingness to participate.

A process - not a form

Informed Consent Document Elements

Informed Consent And Assent Documents

Signature/Date Sample

Exceptions From The standard Informed Consent Procedures
A Process - Not A Form

The informed consent process begins with the presentation of the study to the subject and continues until the subject’s study participation is completed. Obtaining the signature of the subject on an informed consent document is only one part of the process.

The informed consent process emphasizes that the subject is volunteering to participate in a research study and has the ability to withdraw from the study at any time without affecting their medical care. The process starts with exchange of information, usually in an interview setting. The setting and the tone of the interview must be non-coercive. A thorough explanation of all the study along with risks and benefits, and alternatives to participation is essential. The individual must be given an opportunity to ask questions and have those questions satisfactorily answered. The subject must be fully informed in order for consent to be truly voluntary. The informed consent document and other materials are used as a guide to this interview which is documented by the signing of the informed consent document along with a note in the permanent record.

Consent forms should include a statement that there may be unknown risks to the fetus if a woman becomes pregnant while participating in a clinical trial.

The IRB has the authority to observe or appoint a designee to observe the informed consent process and conduct of the IRB approved research process.

Informed Consent Document Elements

No Investigator may involve humans as subjects in research unless the Investigator has obtained the informed consent of that subject or the subjects’ legally authorized representative or a waiver has been granted by the IRB. An Investigator will seek informed consent only under circumstances that provide the prospective subject or the representative sufficient opportunity to consider whether or not to participate and that minimize the possibility of coercion or undue influence. The informed consent document must include the following:

• A clear and concise explanation of the research to be conducted and the procedures to be employed.
• Be written in language appropriate for the targeted subject population (e.g.; eighth grade reading level, English and foreign language versions for a multi-cultural study).
• Clear and precise language detailing all potential risks or discomfort and procedures to minimize such risks, duration of participation, and benefits of participation.
• A statement defining the right of the subject to withdraw at any time without affecting medical care.
• A statement describing alternatives to the proposed research activity, if any exist.
• A statement that the data/information will be kept confidential.
• A statement of whom to contact for answers to pertinent questions about the research and research subjects’ rights, and whom to contact in the event of a research-related injury to the subject.
- A statement that the subject is fully informed and agrees to participate on a purely voluntary basis.

**Informed Consent Document Elements Information**

The IRB has the ability to waive all or a part of the informed consent requirements. For more information, see IRB Policy 15.3 (Waiver of Signed Informed Consent Documents and Waivers of Informed Consent Elements).

For a complete list of Informed Consent Document elements, see the web checklist or IRB Policy 15.1 (Informed Consent).

The IRB also requires specific elements to be included in each consent form in order to comply with federal, state and institutional regulations. Use the Investigator's Checklist for Informed Consent in preparing UAMS consent and assent forms prior to IRB submission. This can be found on the UAMS IRB website.

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**For CAVHS patients, please use the VA Consent Form 10-1086. An interactive version of this form can be found at:**

http://pws.prserv.net/vanjhcs_research/forms/VA_form_consent_10-1086.doc

For more information, visit the CAVHS website at CENTRAL ARKANSAS VETERANS HEALTHCARE SYSTEM (CAVHS) website.

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**Informed Consent And Assent Documents**

The informed consent form for an adult must provide signature lines along with dates and time for subject, Principal Investigator (PI), person obtaining consent, and witness. However, the person obtaining consent cannot serve as the witness, although a study team member may serve as the witness. The person serving as the witness is not required to be present during the explanation of the study, but must be present for the signing of the consent document by the subject. The IRB requires the PI's signature on all subject informed consent documents. The PI may designate someone to explain the consent and does not have to be present when the subject signs the consent but must subsequently sign this document signifying acceptance of the responsibility for all aspects of the study with regards to the enrolled subject.

If children from 7-17 years of age are subjects, signature lines with date and time should also be provided for the child’s assent and for the parent(s) permission. If the IRB deems the risk of the study in children to be Pediatric Category 3 or 4, space for both parents’ signature must be available.

The PI must retain the original signed consent form document in the study file and provide a copy to the subject. The PI must retain copies of the completed consent forms for a period of at least three years following termination of the protocol. The IRB may request the PI to maintain a longer storage period for the executed consent form.

Each subject must be given a copy of the signed informed consent document. A copy of the subject’s informed consent must be placed in the medical records. Pharmacies at each institution may also require a copy of the signed informed consent and protocol before dispensing study drugs.
Additionally, the **process** of informed consent must be documented by an entry in the subject’s permanent or medical records. A progress note should be made that includes:

- The date the subject was entered into the study
- The title of the study
- The name of the Principal Investigator
- The name of the person obtaining the informed consent
- The subject had an opportunity to ask questions about the research and have those questions answered
- **Note:** CAVHS has special requirements for documentation and filing of informed consent. The Investigator should consult the VA R & D Standard Operating Procedures for complete information.

**Signature/Date/Time Sample**

<table>
<thead>
<tr>
<th>Subject</th>
<th>Date/Time</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Principal Investigator</th>
<th>Date/Time</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Witness</th>
<th>Date/Time</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Person Obtaining Consent</th>
<th>Date/Time</th>
</tr>
</thead>
</table>

*The Investigator must retain the original signed consent form document in the study file and provide a copy to the subject.*

If a pharmaceutical company commits to payment of any medical expenses resulting from research injury, the Investigator must furnish a letter, or section of the contract, from the pharmaceutical company to the IRB confirming that commitment. The letter should be signed and dated by a duly authorized official of the company. The letter and consent form must state the extent to which the payment of medical expenses, injuries, and other losses will be made and include any conditions for payment (e.g. refusal to pay prior to submission for payment by subject’s insurance carrier or other third party). If the company agrees to pay only after claims are submitted to the insurance carrier or other third party, the claim submission will indicate that the injury is the result of an adverse drug reaction as part of an investigational trial.
Each page of the consent form should be numbered and dated. (The date will change with each revision of the consent form.)

❖ Exceptions From The Standard Informed Consent Procedures

Emergency Research Protocols Where Prospective Informed Consent is Waived

It is possible to have a protocol involving enrollment of subjects in life-threatening situations when a signed informed consent is not feasible prior to use of an investigational test article. 45 CFR 46.101(i) and 21 CFR 50.24 provide specific requirements that must be met by the Investigator who will conduct research in emergency research protocols. Both the Investigator and a second physician not otherwise participating in the clinical investigation must certify in writing all of the following:

• The subject is confronted by a life-threatening situation necessitating the use of the test article
• Informed Consent cannot be obtained because of an inability to communicate with, or obtain legally effective consent from the subject
• Time is not sufficient to obtain consent from the subject’s legal representative
• There is no available alternative method of approved or generally recognized therapy that provides an equal or greater likelihood of saving the life of the subject
• Risks and benefits of the experimental treatment are reasonable in light of what is known about the condition and risks and benefits of other therapies

Please refer to the “Special Situations” section of the Handbook that elaborates on IRB requirements for these conditions.

Waiver of Written Informed Consent

The IRB may waive the requirement for the Investigator to obtain a signed consent for some or all subjects [45 CFR 46.117(c)] if it finds that:

• The only record linking the subject to the research would be the consent document, and the principal risk to the subject is the potential harm resulting from a breach of confidentiality. In that event, each subject should be asked if he/she wishes to have documentation linking the subject with the research. The subject’s wishes will govern OR
• The research presents no more than a minimal risk of harm to subjects and involves no procedures for which written consent is normally required outside of the research context. In cases where the requirement of documentation is waived, the IRB may require that the Investigator provide the subject with a written statement regarding the research.

The Investigator may request the IRB’s ruling on waived consent at the time the protocol is submitted.
Waiver of the Requirement to Obtain Prospective Informed Consent From Subjects in Non-Emergency Research

Federal regulations allow the IRB the ability to grant a waiver from the requirement to obtain any consent from research subjects in non-emergency research, but only under specific circumstances and only when the decision is made at a convened meeting.

If an Investigator believes neither written nor oral consent can be obtained from any subjects without jeopardizing the conduct of the project, arguments to support this position should be articulated in the application.

In order to grant a waiver, the IRB (Full Committee or Chair/Designee) must document that it believes the request meets the following criteria:

a) The research involves no more than minimal risk to the subjects
b) The waiver will not adversely affect the rights and welfare of the subjects
c) The research could not be practicably carried out without the waiver
d) Whenever appropriate, the subjects will be provided with additional pertinent information after participation.
CHAPTER 6

Continuing Review

Institutional Review Board review is an ongoing process, not a one-time step. Regular reevaluation ensures that research is conducted responsibly. Even in responsibly conducted studies, a one-time review is inadequate, since risks can really be understood only after research has begun, and since the regulations for human subjects research are constantly being refined as the risks and benefits are better understood. Unexpected developments in a project can raise questions about the conduct of the research, and new findings can raise questions about the project.

Continuing Review General Information
IRB Continuing Review Requirements Using ARIA
IRB Continuing Review Process
Notification of Investigators Following Continuing Review
How To View A Letter For Your Protocol
Continuing Review Summary Information
Continuing Review General Information

All full and expedited human use protocols approved by the IRB are subject to substantive continuing review. Studies classified as Exempt must submit an annual update. The Office for Human Research Protections (OHRP) and the FDA require periodic re-evaluation by the IRB of all approved research at intervals appropriate to the study’s degree of risk.

Continuing Review must occur at least once per year and the IRB may require more frequent reviews. There is absolutely no grace period. If Continuing Review approval expires, the study no longer has approval. All interactions with subjects and/or their data must cease and the Investigator should immediately contact the IRB regarding the treatment of enrolled subjects.

The IRB may determine that the degree of risk warrants a more frequent review in order to protect human participants from harm. Some protocols can be reviewed on a quarterly or six-month review cycle, but the approval period will never exceed one year.

How Is The Continuing Review Date Determined? DHHS regulations at 45 CFR 46.108(b) and 109(e) require, respectively, that (1) except when an expedited review procedure is used, each IRB must review proposed research at convened meetings at which a majority of the members of the IRB are present, including at least one member whose primary concerns are in nonscientific areas; and (2) an IRB must conduct continuing review of research at intervals appropriate to the degree of risk, but not less frequently than once per year. The IRB should decide the frequency of continuing review for each study protocol necessary to ensure the continued protection of the rights and welfare of research subjects.

IRB Continuing Review Requirements Using ARIA

Principal Investigators (PI’s) must submit their Continuing Reviews to the IRB using ARIA (Automated Research Information Administrator).

The mechanism for starting the continuing review process is through ARIA’s on-line continuing review module located at https://aria.uams.edu/default.lasso.

For step-by-step instructions on submitting Continuing Reviews, access the Continuing Review Submission Training Handout for ARIA Web Information System.

The documents required for Continuing Review must be uploaded in ARIA. All documents need to be in a PDF Format. If you will be submitting protocols and continuing reviews, you will need to purchase a copy of the software Adobe Acrobat.

NOTE: The latest copies of Adobe Acrobat and Adobe Approval are now available through UAMS IT Procurement for UAMS tagged PCs. To obtain more information or a copy of the software, please contact the Help Desk at (501) 686-8555.

Regardless of continuing review by expedited or full IRB processes, the Investigator must provide the following:

a. A completed ARIA continuing review application;
b. Informed Consent Document – ARIA automatically loads the currently approved consent document, if applicable, into the CR form. The Investigator MUST verify the accuracy of what is listed and correct if inaccurate.

c. In addition to answering yes/no or providing a number in the ARIA form, a status report for all events since the last report should be submitted that includes a summary of the following:
   i. All adverse events,
   ii. Unanticipated problems involving risks to participants/others,
   iii. Complaints about the research and resolution thereof
   iv. Relevant recent literature
   v. Interim findings
   vi. Relevant multi-center trial reports
   vii. Participant benefits
   viii. Current risk-benefit assessment based on study results to date
   ix. Gender, Minority status, and Vulnerable Population status and description
       (Example: Female, Caucasian, Prisoner)
       This may be provided in Step 10 of the form, or in a separately uploaded document.
   x. Reports from Data Safety Monitoring or IND Monitoring Activities required in policy 7.8.

d. If an Investigator allows a study to expire before continuing review approval is received, the investigator must immediately provide the IRB with a list of current participants whose safety might be at risk by stopping research procedures. If the research involves CAVHS, the Investigator must also notify the R&D Committee Chair.

For more information, see IRB Policy 7.6 (Continuing Review).

❖ IRB Continuing Review Process

At the time of initial review, the convened IRB determines how often research projects should be re-evaluated based on the level of risk. Assessment of level of risk includes physical, psychological, social and economic factors. Federal regulations require IRB Continuing Review approval at least once per year. Most research projects are re-evaluated according to this schedule. Protocols more likely to be reviewed at least every six months include:

   a. Involvement of vulnerable populations;
   b. Research conducted internationally;
   c. The involvement of recombinant DNA or other types of gene transfer protocols;
The use of waiver of informed consent procedures, e.g. surrogate consent;

e. Classified research;

f. Research for which subjects would be exposed to additional risks, e.g. breach of confidentiality, continual non compliance with federal regulations, Phase 1 studies, disproportionate number or severity of SAEs;

g. Previous suspension of the researcher due to compliance, record-keeping or other concerns

h. Recommendations from other intra-institutional committees

The Principal Investigator is notified by electronic mail of the continuing review approvals expiration date for continuing review at the time the protocol is initially granted approval. Continuing review reports are required for all active research projects approved by the IRB even if all data analysis has been completed since the last approval unless the study has been closed by the IRB.

The continuing review expiration date may change from year to year. Each time the convened IRB conducts continuing review, the study calendar is reset to the date of the meeting.


Continuing Review reminder notices are sent via electronic mail to the PI three months before the continuing review expiration date. In addition, another email will be sent two months before the end date alerting PI’s to have the CRR submitted four weeks before the end date.

However, the PI remains ultimately responsible for obtaining continuing review, and should not depend solely on IRB notification as a prompt for submitting the Continuing Review Report (CRR) and request for renewal. Investigators are advised to submit Continuing Review Reports at least four weeks prior to expiration to allow sufficient time for processing the report prior to the project’s expiration.

It is important to remember that there is no grace period. Continuing Reviews do not lapse – they expire. If Continuing Review Approval expires, all study activity should cease (not just new subject enrollment) and the IRB should be contacted.

The IRB utilizes the Primary Reviewer system in conducting continuing reviews. A minimum of one reviewer will facilitate the review among the committee members. The Primary Reviewer and the entire committee will have access to the Continuing Review Report.

The Primary Reviewer will present criteria required for review to the convened IRB with discussion of the protocol before a vote for continuing approval can be made. The IRB will vote separately on each continuing review. The vote will be recorded in the meeting minutes.

Continuing review may be conducted by expedited review only where the study falls into one of the expedited review categories and is minimal risk. Expedited review may also be used for continuing review if a study has been closed to accrual and intervention has been completed, but the Investigator is still collecting follow-up data.
Continuing review rulings are as follows:

**Protocol approval:** Follows review of satisfactory information submitted by Investigator regarding an ongoing project.

**Protocol approval Deferred (Major or Minor):** The information submitted by the Investigator regarding an ongoing project is not sufficient for re-approval. Additional information from the Investigator is required. Minor revisions may be reviewed through the expedited process. Major revisions in the project as submitted must be addressed by the convened IRB. This information must be received as requested by the IRB.

**Protocol Suspended:** Suspension follows review of information submitted by Investigators regarding an ongoing project that addresses issues of concern or serious problems in risk/benefit analysis. Protocol enrollment and study procedures must stop until additional information can be reviewed by the convened IRB.

**IMPORTANT REMINDERS:**

Timely submission of continuing review reports (CRR) is the Investigator’s responsibility and is essential to the continuation of the study.

A copy of all continuing review reports (CRRs) and approval letters should be kept in the Investigator’s study regulatory file.

All protocols not approved by the IRB by the project’s continuing review expiration date are no longer approved. All new accrual must cease and all further subject (or data) interactions must cease unless specifically approved by the IRB due to subject safety concerns.

**Notification Of Investigators Following Continuing Review**

All of the committee’s action on the protocol’s continuing review submission will be posted on ARIA in the LETTERS section.

Once the PI views the information in the LETTERS section posted on the ARIA website for the protocol, the PI should make the required corrections, clarifications or modifications, and resubmit them to the IRB office via ARIA.

It is the PI’s responsibility to keep track of each Continuing Review submission and to check the ARIA website to know the current status of the protocol. Use the following steps to view a letter for your protocol:
How To View A Letter For Your Protocol

- Access the ARIA website at https://aria.uams.edu/default.lasso.
- Select PI LOGIN.
- Select the IRB # of the protocol you wish to view.
- The Protocol Detail screen appears with five options available:
  1. Documents
  2. Letters
  3. Adverse Events
  4. Continuing Reviews
  5. Modifications
- Select option 2, Letters.
- The Letters information appears with the following titles:
  Status
  IRB#
  Message Type
- Click on any of the above titles.
- The letter opens via Internet Explorer and allows you to print from the browser.

Continuing Review Summary Information

For studies where continuing review approval has expired and only upon PI request, the IRB will determine on a case-by-case basis if it is appropriate for safety reasons to allow continued interactions and/or interventions with currently enrolled subjects. A notice is sent to the PI. The study will be terminated 30 days after study suspension notification if no response has been received from the Investigator.

If the IRB’s review of a project requiring continuing review results in termination, a new IRB application may be required to continue with the research. No new subjects may be enrolled, all ongoing research activities must stop, and subjects currently participating should be notified that the study has been terminated. The regulations make no provision for any grace period extending the research beyond the date the CR expires.

Termination notices due to non-compliance with the federal regulations for continuing review will be sent to the PI, the Department Chair, and the Office of the Vice Chancellor for Academic Affairs and Research Administration (VCAA/RA). The IRB must also notify study sponsors, the FDA and OHRP (if the studies are government funded). If the study is done at CAVHS, the VA Research and Development Committee (VA R&D) along with the Office of Research Compliance (ORC) will be notified of termination.
CHAPTER 7

Amending A Protocol

This section details the steps involving amending a research protocol.

Protocol Amendments
Protocol Amendments

During the course of a research activity, the sponsor and Investigator may decide that elements of the research require modification. If an Investigator or sponsor finds it necessary to deviate in any way from an IRB approved protocol, consent forms, or eligibility requirements, an amendment or request in writing to the IRB must be submitted with the changes highlighted. If a change affects the approved consent form, it will be necessary to submit a revised consent with changes highlighted. New consent forms must have the version and date revised. The protocol amendments will be considered by the fully convened IRB or by the IRB Chair/Designee if the amendment is considered minor in nature.

Changes in the research may not occur until IRB approval of the amendment is received unless there is an immediate threat to the health of the participant. If such a situation were to occur, it would be the PI’s responsibility to immediately report the event to the IRB as a protocol deviation and serve notice that an amendment to the protocol will be forthcoming.

Major changes to an existing protocol, such as a change in the aim of the study, or the degree of risk to the subject may require that a new protocol be submitted (usually with a new title) and the old protocol be closed.

After IRB approval of the protocol amendment, a copy of the approval letter should be sent to the sponsor by the Investigator. The VA R & D Committee will also require copies of protocol amendment approval for research at CAVHS. A copy of the submission, approval letters, and amendments should be kept in the study’s regulatory files.

Any changes or amendments to an already approved protocol must be submitted for review and approval by the IRB prior to initiation unless a serious safety issue exists.
CHAPTER 8

Research Record-Keeping And Reporting

This section details the information involving research record-keeping and reporting.

ARIA Information
Record-Keeping Responsibilities Of The Principal Investigator
Investigator’s Responsibilities For Test Article Accountability
Subject Information Regarding Investigational Drugs Or Devices
Investigator IRB Reporting Responsibilities
Change in Principal Investigator
Communicating With Subjects
Reporting Responsibilities Of The Principal Investigator To The IRB
Adverse Event Reporting
How To Report A Death Or Serious Adverse Event
Reporting Protocol Deviations
Reporting Protocol Violations
Reporting Notification Of Pending Audits Or Inquiries
Reporting to Appropriate Federal Oversight Bodies, Institutional Officials and Research Sponsors
**ARIA Information**

All reporting (local, non-local, and death) must be submitted through the Automated Research Information Administrator’s (ARIA) on-line module located at [https://aria.uams.edu](https://aria.uams.edu)

For assistance with obtaining an ARIA username and password, please contact the IRB Office at 501-686-5667.

**Record-Keeping Responsibilities Of The Principal Investigator (PI)**

Proper record keeping is integral to the validity and reliability of data collected during research trials. It is the PI’s responsibility to oversee the general organization and design of study records, both paper and electronic, and assure that all records are authentic. All data recorded on study recording forms and procedures performed should be supported by documents filed in the study file. Each study involving human subjects must have a log listing those enrolled and those who were approached to enter the study with identifying information. Identifying information can be encrypted.

The PI is also responsible for the proper organization of regulatory documents: such as protocols, protocol amendments, IRB submissions, CRR and approval letters, reports to all appropriate entities on adverse events, deaths, protocol violations and deviations.

Each study should have the following general records:

<table>
<thead>
<tr>
<th>Regulatory</th>
<th>Individual Subject Files</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subject Log</td>
<td>Original signed informed consent form</td>
</tr>
<tr>
<td>Copies of all IRB correspondence</td>
<td>Copies of study case recording/reporting forms</td>
</tr>
<tr>
<td>Approved Protocol</td>
<td>(CRFs)</td>
</tr>
<tr>
<td>Approved Consent Form</td>
<td>Subject medical record number and emergency</td>
</tr>
<tr>
<td>IRB Approval Letters</td>
<td>contact information</td>
</tr>
<tr>
<td>Other Institutional approvals</td>
<td>Supporting Documentation for: *</td>
</tr>
<tr>
<td>Continuing review reports</td>
<td>Inclusion/Exclusion criteria</td>
</tr>
<tr>
<td>Investigator’s Brochure</td>
<td>Results of tests or procedures</td>
</tr>
<tr>
<td>Correspondence with sponsors</td>
<td>Adverse events</td>
</tr>
<tr>
<td>Special Committee approvals</td>
<td>Deaths</td>
</tr>
<tr>
<td>Study Standard Operating Procedures</td>
<td>Communications with subject and follow up exams</td>
</tr>
<tr>
<td>Sample questionnaires</td>
<td>Protocol Violations</td>
</tr>
<tr>
<td>Sample study forms with instructions</td>
<td>Protocol Deviations</td>
</tr>
<tr>
<td>Reports of unanticipated problems involving</td>
<td></td>
</tr>
<tr>
<td>risks to participants or others</td>
<td></td>
</tr>
<tr>
<td>Drug Accountability Records</td>
<td></td>
</tr>
</tbody>
</table>
Drug/Equipment Shipping Receipts
Data Safety Monitoring Reports (if applicable)

* Completed study recording forms are not considered supporting documentation. Additional records are needed.

Example: A lab value recorded on a study form must be supported by a clinical laboratory report of that test.

These records and any other that assists in collection of data must be consistently maintained. The PI may delegate elements of record keeping activities, but remains responsible for accuracy, authenticity, validity and completeness of all study records. Investigators should consult each specific protocol for the length of time that study records should be maintained.

If the study is being carried out at Central Arkansas Veterans Healthcare System (CAVHS), the Investigator has additional record keeping responsibilities. A complete list can be obtained from the VA Research and Development (R & D) Committee. For more information regarding VA submissions, contact the CAVHS Administrative Office at 501-257-4816.

Investigator’s Responsibilities For Test Article Accountability

A pharmaceutical product, device or any other investigational product must be received, maintained, stored, inventoried and accounted for by the Investigator according to Federal Guidelines. The Investigator is responsible for the control and documentation of all test articles. If investigational drugs are involved in a study, shipment from the sponsor must be coordinated through the institution’s pharmacy. Sponsors may ship investigational drugs directly to a subject only in very rare circumstances. It is also against federal law for anyone other than the sponsor to send investigational drugs or devices to an Investigator. Arrangements with the pharmacy for the receipt of all investigational drugs should be completed prior to submitting the protocol for approval.

Example: You are new to the institution and plan to continue your study of implantable catheters. The protocol has received IRB approval. You must receive a new batch of catheters from the sponsor. You cannot obtain them from your previous workplace.

The Investigator must assure the maintenance of a drug or device record that is current and includes the following:

- Date of delivery and shipping Invoice including name and address of consignee, type and quantity of drug or device and date of shipment
- Inventory log, with unique code numbers, reflecting use by each subject
- Location and environmental conditions of storage
- Security of storage (tamper-proof)
- Expiration dates, if applicable of drugs and devices
- Records validating that appropriate personnel used the drug or device according to protocol

For Investigational Drugs: Documentation should include the amount of drug that was dispensed, unused by the subject, wasted by the research staff and returned to the pharmaceutical company.
Documentation records must also reflect subject identification, the reason for waste or return, and batch or lot numbers of returned materials.

*For Investigational Devices:* Documentation of the device used, including batch number, lot or identification number, subject identification, patient materials provided, devices returned to company and malfunctioning devices. Investigators must submit an “Acknowledgement of Investigator Responsibility for Investigational Devices” form with ARIA Submission. Form can be found at the IRB website.

The Investigator must assure that test articles are administered or dispensed under his or her personal supervision or the supervision of the appropriate competent personnel. Arkansas State Law requires that only a physician or pharmacist may dispense drugs. An Investigator shall not supply a test article to any other person for administration or to use upon subjects for any other purpose, without the prior authorization of the sponsor [CFR 21 812.110 (c)].

If the test article is a controlled substance, the Investigator must assure that it is appropriately stored, dispensed and accounted for and take reasonable precautions against the drug’s diversion. Controlled substances must be administered only by those legally allowed to do so.

Unused test articles must be returned to the sponsor. Documentation of the shipment should be retained with the drug/device record. For studies conducted at the VA, the disposal of unused articles should be done through the pharmacy after a letter of direction sent by the PI.

- **Subject Information Regarding Investigational Drugs Or Devices**

  The Investigator or his designee must explain the correct use of the investigational product to each subject. Subjects should be followed up periodically to assure that they are using the products correctly. Additionally, sponsors often include device product identifiers, including lot numbers. These should be given to the subject. A copy of lot numbers or unique identifiers should be recorded in each subject’s medical record. Drug information must be recorded in the subject’s drug dispensing log.

- **Investigator IRB Reporting Responsibilities**

  Communication between the Investigator and the IRB is critical to the Institution’s ability to conduct research using human subjects. Timely communications from the PI and appropriate guidance by the IRB and the institution where the research is being performed is necessary for the protection of the subject, the maintenance of research compliance and the elevation of the quality of the research.

- **Change in Principal Investigator**

  The IRB must be notified within 30 days of a change in the principal investigator. When changing investigators, please submit the following:

  1. Protocol Amendment/Modification Form through ARIA.
  2. A letter from the principal investigator indicating the change in responsibility.
3. A letter from the new investigator accepting the responsibility for the research, and the new investigator’s CV if not already part of the study file.

4. Revised protocol, consent forms, HIPAA authorizations or advertisements, as applicable.

5. Revise FDA Form 1572 if applicable.

Any IRB project associated with a Principal Investigator (PI) who has left the University of Arkansas for Medical Sciences, or other institutions using the UAMS IRB as the IRB of record, cannot continue without modification. These projects must be closed or a new PI must be signed to take full responsibility for the project and the subjects enrolled in the project. If the study cannot be closed because of safety issues related to participant involvement, it is mandatory that a local, affiliated investigator be named as PI.

If a significant difference in the background, training and expertise exists between the two PIs, the IRB may consider the change in PI to be a major revision, requiring a full Board review before the change can be officially implemented. A change in sub-investigators must also be reported to the IRB. It is the responsibility of the PI to notify the IRB when a sub-investigator is dropped from a study and when a new sub-investigator joins an IRB-approved project. Sub-investigator changes are considered minor revisions, but must also be approved before the change can be implemented.

 comunicating with subjects

Serious adverse events, deaths, changes in protocol and other new information regarding a study may need to be reported to subjects. Letters of this nature must be approved by IRB prior to mailing.

Reporting Responsibilities Of The Principal Investigator To The IRB

The table below describes what investigators must report to the IRB:

<table>
<thead>
<tr>
<th>Investigator Must Report:</th>
<th>Time Frame for Reporting:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Serious, Unanticipated and Related events</td>
<td>Within 10 days of the event</td>
</tr>
<tr>
<td>• Deaths</td>
<td>Immediately, if the death is related to the research. For subjects off protocol whose death is not related to the study, report death with the next continuing review.</td>
</tr>
<tr>
<td>• Protocol deviations</td>
<td>Within 10 days, if the deviation represents a significant alteration in the approved protocol and /or if it affects the safety or welfare of the subject. Otherwise, report with the next continuing review.</td>
</tr>
</tbody>
</table>
### Investigator Must Report:

<table>
<thead>
<tr>
<th>Investigator Must Report:</th>
<th>Time Frame for Reporting:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Protocol violations</td>
<td><strong>Within 10 days</strong>, if the violation represents a significant alteration in the approved protocol and/or if it affects the safety or welfare of the subject. Otherwise report with the next continuing review.</td>
</tr>
<tr>
<td>• Changes to approved research procedures or protocols (amendments)</td>
<td><strong>Prior to implementation</strong></td>
</tr>
<tr>
<td>• Noncompliance with conducting of research protocols</td>
<td><strong>Within 10 days</strong> of discovery of noncompliance.</td>
</tr>
<tr>
<td>• Restrictions, suspension or termination of study by the sponsor or principal investigator by funding source, regulatory body or administration</td>
<td><strong>Within 10 days</strong> of notification of restrictions or suspension.</td>
</tr>
<tr>
<td>• Notifications of Pending Audits or Inquires by external bodies (e.g. sponsors, FDA, NCI, or NIH). Investigators are required to report any communication from a federal or state department or agency or sponsor that questions the conduct of research or suggests an impending inquiry, audit or investigation. The PI must inform both the IRB and the Office of Research Compliance</td>
<td><strong>Within 10 days</strong> of notification of audit or inquiry.</td>
</tr>
</tbody>
</table>

For more information, see [IRB Policy 10.2](#).

**Adverse Event Reporting**

Your responsibility as a Principal Investigator includes the prompt reporting to the IRB of serious, unexpected and related events associated with the use of either investigational drugs or devices or other research procedures. A death of a subject that is not protocol related and part of long-term follow up (e.g. following until death on oncology protocols) should be reported with continuing review. Reporting to the IRB does not substitute for a Principal Investigators’ responsibility of reporting to a Sponsor.

A serious adverse event is any adverse experience occurring at any dose that:
• Results in death.
• Is life-threatening (places the subject at immediate risk of death from the experience as it occurred).
• Results in a persistent or significant disability/incapacity.
• Results in or prolongs an existing in subject hospitalization (even if in the hospitalization is a precautionary measure for observation).
• Is a congenital anomaly/birth defect in offspring of subjects taking the product, regardless of time to diagnosis.
• Represents any other important medical event that, based upon appropriate medical judgment, may jeopardize the participant and may require medical or surgical intervention to prevent one of the outcomes listed above.

You **MUST** report any death to the IRB office if:

• Protocol requires reporting of the death to the study sponsor or the FDA.
• The subject was being actively treated on an approved research protocol at the time of death.
• During the course of long-term follow up after completion of the experimental (i.e. active treatment) portion of an approved study protocol, the Investigator becomes aware of the death of the research subject.

You do not need to report the death of a subject if:

• The study protocol has been officially closed and a final report has been received and accepted by the IRB.

**How To Report A Death Or Serious Adverse Event**

The Investigator reports deaths or serious adverse events by completing and submitting the Serious Adverse Event Reporting Form online on ARIA. The PI must also submit all SAE reports (local, non-local, death) online in the report format given and upload the documents at the prompt. In addition, the PI must also include any correspondence sent to the sponsor or FDA regarding the event along with any additional information related to the study. Remember to send a copy of the form and your report to your institution’s research committees, e.g. VA Research & Development Committee.

For more information, see [IRB Policy 10.2 (Unanticipated Problems Involving Risks to Participants or Others – Investigator Reporting Requirements and IRB Actions)](#).

**Reporting Protocol Deviations**

Protocol Deviations are study events that are not covered under the approved research protocol, which represent a failure to comply with the protocol. *Example: A subject does not have the kidney biopsy, which is required six months after beginning transplant medication because she is in the ICU.* The PI should report a protocol deviation to the IRB immediately, if it represents a significant alteration in the approved written protocol and/or affects the safety and welfare of the subject. Otherwise, report
with the next continuing review. Note: Protocol deviations are often referred to as “protocol exceptions”. For the purpose of IRB reporting, the two are the same.

Reporting Protocol Violations

Protocol Violations are those events clearly occurring outside of the approved research activity, which also represent a failure to comply with the protocol. The terms protocol deviation and protocol violation are similar, although a protocol violation refers to more serious non-compliance, which more often leads to exclusion of subjects from eligibility analysis or their discontinuation from the study.

Example: Enrolling a subject in a cancer study when the subject has no histological or clinically proven cancer is considered a protocol violation when a tissue diagnosis of cancer is a protocol inclusion criterion.

The PI must report protocol violations to the IRB, the sponsor, and all participating institutions. The report must be issued immediately if the health of welfare of the subject was jeopardized. Otherwise, report with the next continuing review.

Reporting Notification Of Pending Audits Or Inquiries

Investigators conducting research involving human subjects are required to report ANY COMMUNICATION from a federal or state department or agency or sponsor that questions the conduct of research or suggests an impending inquiry audit or investigation. The Principal Investigator (PI) MUST submit through ARIA a detailed description of the proposed inquiry within 10 days from the notification of the Investigator. It is strongly suggested that the PI first inform the IRB and the Office of Research Compliance (ORC) by phone or electronic mail immediately upon notification of inquiry.

For more information, see IRB Policy 10.2 (Principal Investigator Reporting Requirements).

Reporting to Appropriate Federal Oversight Bodies, Institutional Officials and Research Sponsors

It is the responsibility of the UAMS IRB to assure that reporting required under appropriate regulations, the terms of the Federal Wide Assurance, and IRB Policy is accomplished. When required reporting includes an affiliate organization utilizing the UAMS IRB, the mechanisms will be outlined in an agreement with each affiliate.

The IRB will assure the following issues are reported to appropriate agencies, institutional officials and the convened IRB within a reasonable timeframe from the final determination of the convened committee:

1. Any unanticipated problems involving risk to participants or others
2. Any serious or continuing non-compliance with this policy or the requirements or determinations of the IRB
3. Any suspension or termination IRB approval by the convened committee

For more information, see IRB Policy 2.6 (Reporting to Appropriate Federal Oversight Bodies, Institutional Officials and Research Sponsors).
Changing Study Protocol/Modifications to Previously Approved Research

All major and minor amendments or revisions must be submitted to the IRB for approval. The IRB Chair or his or her designee shall be the only one to determine as to whether an amendment is major or minor, based on degree of risk involved in the change.

The Investigator will do the following:

Make all amendment or modification requests through ARIA. Each modification will include:

1. Description of the changes;
2. Reason for the change;
3. Investigator’s opinion as to impact of change on study and on participants; and
4. Whether or not changes are needed to the consent form.

5. All documents, including but not limited to consents, protocols, recruitment materials, and Form 1572s, to be modified. If a sponsor or a granting agency has requested the amendment, a copy of the communication from the sponsor, as well as a copy of the amendment and/or the amended protocol should also be included. If the change affects the consent, provide both a tracked and a clean document.

Note: The IRB reserves the right to defer review if the changes are not highlighted or tracked on the document to be revised. If a document is received from a sponsor where tracking changes is not possible then an outline of the protocol changes must be provided.

No change should be implemented until IRB approval, and as applicable Sponsor approval, is received. The only exception is a change necessary to eliminate apparent immediate hazards to the research participants. In such cases, the Investigator will promptly inform the IRB, and as applicable the Sponsor, of the implemented change.
CHAPTER 9

Emergency Situations

This section gives information about emergency use of an investigational drug or Biologic, and emergency use of an Unapproved Medical Device.

Emergency Use of an Investigational Drug or Biologic

Emergency Use of an Investigational Device
Emergency Use of an Investigational Drug or Biologic

The purpose of this section of the handbook is to explain the limited circumstances where prior IRB approval is not required in the emergency use of an investigational drug or biologic.

Emergency Use means the use of a test article on a human subject in a life-threatening situation in which no standard acceptable treatment is available, and in which there is not sufficient time to obtain IRB approval.

Test Article. A test article is defined as any drug, biological product or medical device for human use, human food additive, color additive, electronic product, or any other article subject to regulation under the act or under sections 351 and 354-360F of the Public Health Service Act. As used hereafter, it shall only apply to investigational drugs or biological products. Emergency Use of a Medical Device is addressed in Policy 18.4.

Life Threatening. Life threatening includes the scope of both life threatening and severely debilitating, as defined below:

- Life threatening means diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted and diseases or conditions with potentially fatal outcomes, where the end point of clinical trial analysis is survival. The criteria for life threatening do not require the condition to be immediately life threatening or to immediately result in death. Rather, the subjects must be in a life-threatening situation requiring intervention before review at a convened meeting of the IRB is feasible.

- Severely debilitating means diseases or conditions that cause major irreversible morbidity. Examples of severely debilitating conditions include blindness, loss of arm, leg, hand or foot, loss of hearing, paralysis or stroke.

The IRB acknowledges that there will be certain limited circumstances where IRB approval will not be obtainable prior to the first use of a test article. FDA requirements for emergency use must be met, and the IRB requires prior notification of test article use. The IRB will acknowledge this one time use and require a follow up report. Any subsequent use of the test article will require full IRB review and approval prior to use. However, FDA acknowledges that it would be inappropriate to deny emergency treatment to a second individual if the only obstacle is that the IRB has not had time to convene a meeting.

Under FDA regulations emergency use of a test article is considered research. Under DHHS regulations emergency use of a test article is not research because it is not a systematic investigation designed to generate or contribute to generalizable knowledge. To maintain this distinction data from an emergency use cannot be used in any report of a prospectively conceived research activity.
The Principal Investigator will do the following:

- Obtain an IND (Investigational New Drug) number from the manufacturer, if possible, or if the manufacturer elects not to name the PI on the IND, the PI should then contact the FDA directly for an IND or obtain evidence of an IND Exemption.

- Notify the IRB, verbally, when a situation arises that calls for the emergency use of an investigational drug or biologic without an approved study protocol to obtain a determination from the IRB chair that the situation meets the regulatory requirements for an emergency use, and submit a letter to the IRB stating the following:
  - a. The participant was in a life-threatening situation
  - b. There is no standard acceptable treatment available
  - c. There is not sufficient time to obtain IRB approval.
  - d. The diagnosis, test article to be used and proposed use, and hospital.

- Obtain the consent of the participant or the legally authorized representative of the participant unless the PI and a physician who is not otherwise participating in the clinical investigation both make all of the following assurances:
  - a. Participant in a life threatening situation
  - b. All other available treatments are either unproven or unsatisfactory
  - c. Participant unable to give consent due to their medical condition
  - d. There is no time to obtain consent from LAR

- If in the PI’s opinion, immediate use of the test article is necessary to save the participant’s life and time does not permit seeking the opinion of a physician not otherwise involved, the PI should make the above determinations and proceed with the use.

- Within 5 days of the use of test article, the PI should submit a follow up report to the IRB that includes
  - a. Name of test article used, detailed conditions of use and date of IRB verbal acknowledgement
  - b. Date, time and location of use
  - c. Participant’s diagnosis and outcome if known
  - d. Any adverse events or unanticipated problems
  - e. Copy of the signed informed consent OR physician’s assurance as provided for above.

- Evaluate the likelihood of needing to use the test article again. If additional use is anticipated, immediately submit protocol and consent for full IRB review under separate ARIA submission.
The IRB Chair or Vice Chair will do the following:

- Evaluate the Investigator’s notice of intent to use a test article under these guidelines to determine whether FDA regulatory requirements are met.
- Request the information listed above, assessment of consent process, or any other materials that will aid in the evaluation.
- Provide initial verbal acknowledgement and shortly thereafter, written acknowledgement, through ARIA, of intent to use test article.
- Review the follow-up report and arrange for full committee notification on next available agenda.

Emergency Use of an Investigational Device

The purpose of this section of the handbook is to explain the limited circumstances where prior IRB approval is not required in the emergency use of an unapproved investigational device.

Emergency Use means the use of a test article on a human subject in a life-threatening situation in which no standard acceptable treatment is available, and in which there is not sufficient time to obtain IRB approval.

Life Threatening. Life threatening includes the scope of both life threatening and severely debilitating, as defined below:

Life threatening means diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted and diseases or conditions with potentially fatal outcomes, where the end point of clinical trial analysis is survival. The criteria for life threatening do not require the condition to be immediately life threatening or to immediately result in death. Rather, the subjects must be in a life-threatening situation requiring intervention before review at a convened meeting of the IRB is feasible.

Severely debilitating means diseases or conditions that cause major irreversible morbidity. Examples of severely debilitating conditions include blindness, loss of arm, leg, hand or foot, loss of hearing, paralysis or stroke.

Test Article: A test article is defined as any drug, biological product or medical device for human use, human food additive, color additive, electronic product, or any other article subject to regulation under the act or under sections 351 and 354-360F of the Public Health Service Act. As used hereafter, it shall only apply to unapproved investigational medical devices. Emergency Use of Drugs or Biological Products are addressed in Policy 18.3.

The IRB acknowledges that there will be certain limited circumstances where IRB approval will not be obtainable prior to the first use of an unapproved investigational device. FDA requirements for emergency use must be met, and the IRB requires prior notification of the use. The IRB will acknowledge this one time use and require a follow up report. Any subsequent use of the test article will require full IRB review and approval prior to use, and an approved IDE.
Under FDA regulations emergency use of a test article is considered research. Under DHHS regulations emergency use of a test article is not research because it is not a systematic investigation designed to generate or contribute to generalizable knowledge. To maintain this distinction data from an emergency use cannot be used in any report of a prospectively conceived research activity.

The Principal Investigator will do the following:

- Determine whether device can be used under manufacturer’s IDE or be able to justify to FDA that all emergency requirements are met.

- Notify the IRB, verbally, when a situation arises that calls for the emergency use of an unapproved investigational device without an approved study protocol to obtain a determination from the IRB chair that the situation meets the regulatory requirements for an emergency use, and submit a letter to the IRB stating the following:
  a. The participant was in a life-threatening situation
  b. There is no standard acceptable treatment available
  c. There is not sufficient time to obtain IRB or FDA approval.
  d. The diagnosis, test article to be used and proposed use, and hospital.
  e. Assess the potential for benefits and have substantial reason to believe the benefits will exist
  f. Assure the IRB that an emergency actually exists and decision is based on that and not that the IDE approval process takes more time than available.

- Assure the IRB that the device manufacturer will notify the FDA of the emergency after shipping of the device. An unapproved device may not be shipped in anticipation of an emergency.

- Obtain the consent of the participant or the legally authorized representative of the participant unless the PI and a physician who is not otherwise participating in the clinical investigation both make all of the following assurances:
  a. Participant in a life threatening situation
  b. All other available treatments are either unproven or unsatisfactory
  c. Participant unable to give consent due to their medical condition
  d. There is no time to obtain consent from LAR
• If in the PI’s opinion, immediate use of the test article is necessary to save the participant’s life and time does not permit seeking the opinion of a physician not otherwise involved, the PI should make the above determinations and proceed with the use.

• Within 5 days of the use of test article, the PI should submit a follow up report to the IRB that includes
  a. Name of test article used, detailed conditions of use and date of IRB verbal acknowledgement
  b. Date, time and location of use
  c. Participant’s diagnosis and outcome if known
  d. Any adverse events or unanticipated problems
  e. Copy of the signed informed consent OR physician’s assurance as described above

• Evaluate the likelihood of needing to use the test article again. If additional use is anticipated, immediately submit protocol, consent and approved IDE for full IRB review under separate ARIA submission. If IDE application is disapproved by the FDA, the device cannot be used even in an emergency.

The IRB Chair or Vice Chair will do the following:

• Evaluate the Investigator’s notice of intent to use a test article under these guidelines to determine whether FDA regulatory requirements are met.

• Request the information listed above, assessment of consent process, or any other materials that will aid in the evaluation.

• Provide initial verbal acknowledgement and shortly thereafter, written acknowledgement, through ARIA, of intent to use test article.

• Review the follow-up report and arrange for full committee notification on next available agenda.
 Procedures during business hours

If the need for emergency use arises during the business day, the procedure to secure a waiver is as follows:

- The physician notifies the IRB office by telephone of a pending request for emergency use.
- The IRB administrative staff refers the physician to the IRB chair, or to a physician designated by the chair, to secure oral approval.
- Within five working days of the request, the physician provides the IRB office with written documentation of the oral approval, a copy of the unsigned consent form used to document informed consent of the subject, and a report of the experience.
- The IRB provides the physician with written confirmation of its approval. This should be maintained with the physician’s records.

Many drug companies require IRB certification of approval to release drugs or biologics. The Investigator is responsible for the paperwork required by sponsors, drug companies, and the FDA.

 Procedures outside of business hours

If the need for emergency use arises when the IRB office is not open, the physician should:

- Secure approval, or agreement, from another physician who is not involved in the treatment of this particular patient,
- Alert the IRB office of the intended use,
- Report the action to the IRB office in writing within five working days.

Please note: Neither the common rule or the FDA regulations provide for expedited IRB approval in emergency situations. Therefore, “interim”, “compassionate”, “temporary” or other terms for an expedited approval process are not authorized. The IRB must either convene and give “full board” approval of the emergency use or, if it is not possible to convene a quorum with the time available, the use may proceed without IRB Approval. When this situation exists, the IRB may issue an acknowledgement letter that they have been made aware of the use.
CHAPTER 10

Genetic Research

This section deals with genetic research.
Genetic Research

The greatest risk to subjects participating in genetic research is the inappropriate release of personal and private information. Therefore, concerns for how Investigators will maintain the confidentiality of the data and specimens collected during the conduct of the study is a primary concern to the IRB.

The protocol and informed consent should address the following points:

- Study information is coded and personal identifiers maintained securely
- Consent forms include information about who will receive the data derived (e.g. the subject, family members, non-participation family members, family physician, other Investigators)
- Information as to whether clinically relevant information may be uncovered during the course of the study and whether subjects will be given the opportunity to decline receiving this information
- If children are to be research participants, how will permission be obtained from parents, how will assent be obtained from children and how will data be handled
- Participants may derive no benefit from participation.
- Study data should not be recorded in the subject’s medical record; separate research records with controlled access are preferred.
- Whether there will be any possibility of individually identifying subjects
- Inform subjects of any special risks associated with their participation (e.g. changes in family relationships, risks to privacy, confidentiality, insurability, employability, immigration status, and paternity suits)
- Indicate if general study results will be made available to subjects
- Whether genetic counseling will be made available and who will pay for this counseling
- Length of time in maintaining specimens (limited, indefinitely) and/or discarding specimens
- Subjects’ wishes to be re-contacted if clinically relevant information is developed
- If the Investigator intends to share specimens acquired during the research with other Investigators, this information must be included in the consent form and participants given the choice whether they are willing to permit this or not
- Should there be a potential commercial value derived from the research, the subject must be informed as to whether they will be asked to waive any rights or control over the tissue so used
- If the research involves the manufacture of a drug or biologic that is to be administered as a part of research, the Investigator should follow the 21CFR 210 “Good Manufacturing Practices” when required.
CHAPTER 11

Investigational Drugs and Medical Devices

This section concerns investigational drugs and medical devices.

Using Investigational New Drugs
Using Investigational New Devices
Use Of Medical Devices In Research Studies
Studies Involving Devices Known To Be Of Significant Risk
IRB’s Role In Distinguishing Between SR and NSR Device Studies
Investigator’s Responsibilities Related To Investigational Devices
Studies Of Devices With The FDA 510K Designation
Emergency Use Of Investigational Devices
Humanitarian Use Devices (HUD) Or Custom Devices
Investigational Devices That May Be Eligible For Exemption
Using investigational new drugs

Researchers who employ a test article classified by the Food and Drug Administration as an investigational new drug must assure the IRB that they are complying with the FDA's IND regulations (21 CFR 312). The IND number assigned to the test article must be filed with the IRB when the application for review is submitted.

Experimental drugs used in humans require an IND number if they are used to develop information about their safety or efficacy.

Approved, marketed drugs may also require an IND, if proposed use is:

- Different from its previously FDA-approved use,
- Administered by an unapproved route or method of delivery, or
- An altered dosage form,
- Shipped by interstate commerce in order to conduct a clinical trial.

The FDA has published several exemptions to the IND requirements. Roughly, a clinical investigation may be exempted from the IND requirements if the drug is lawfully marketed in the U.S. and all the following apply:

- The results will not be reported to the FDA to support a new indication for use nor to support any other significant change in the labeling of the drug;
- The investigation will not be used to support a significant change in the advertising of a prescription drug that is already on the market;
- The investigation does not involve a route of administration, dosage level, use in a patient population, or other factor that significantly increases the risks (or decreases the acceptability of the risks) associated with the use of the drug product;
- The investigation is conducted in compliance with the requirements for institutional review set forth in Part 56 and with the requirements for informed consent set forth in Part 50; and
- The investigation is conducted in compliance with the requirements of section 312.7, which concerns the promotion and sale of investigational drugs.

The IRB requires detailed discussion of all these points when an exemption from IND requirements is requested.

For more information on the criteria for studies classified as Exempt under the Federal Regulations, see IRB Policy 7.3 (Exempt Categories of Research) and for more information on Expedited Review, see IRB Policy 7.5 (Expedited Review).

Using investigational new devices

Researchers who employ a significant risk device classified by the Food and Drug Administration as an investigational device must assure the IRB that they are complying with the FDA's Investigational Device Exemptions (IDE) regulations (21 CFR 812 or 814). The IDE number assigned to the test article must be filed with the IRB when the application for review is submitted.
Use Of Medical Devices In Research Studies

The IRB considers an investigational device to be one that is not currently marketed in the United States. According to 21 CFR 812, two types of device studies exist. These types are “significant risk” (SR) and “nonsignificant risk” (NSR). An SR device is defined as “a study of a device that presents a potential for serious risk to the heath, safety, or welfare of a subject and (1) is an implant; or (2) is used in supporting or sustaining human life; or (3) is of substantial importance in diagnosing, curing, mitigating or treating disease, or otherwise prevents impairment of human health; or (4) otherwise presents a potential for serious risk to the health, safety, or welfare of a subject.” An NSR device study is defined as, “one that does not meet the definition for a significant risk study”.

NSR is not to be confused with the term “minimal risk” and studies of this type are not eligible for expedited review.

Studies Involving Devices Known To Be Of Significant Risk (SR)

Devices that are known to be SR require an IDE from the FDA. A list of known SRs can be found in the FDA website [www.fda.gov/cdrh/d861.html](http://www.fda.gov/cdrh/d861.html).

For studies involving SR devices, an IDE and appropriate information concerning the history of the device's use, proposed investigation plan, description of subject selection criteria and monitoring procedures must be included with the submission packet.

IRB’s Role In Distinguishing Between SR and NSR Device Studies

The IRB acts as the surrogate of the FDA with respect to the review and approval of NSR studies. If an Investigator OR sponsor proposes the use of a device it claims to be NSR, the IRB may agree and approve the study. If the IRB grants approval of an NSR device, the study may begin immediately and no IDE will be required.

If the IRB does not agree and believes the device poses significant risk, the study may not begin until both the IRB and the FDA approve the investigation. The IRB will notify the sponsor and Investigator of the SR decision. The Investigator will be required to obtain an IDE from the FDA. The study, if approved by IRB, will be conducted as a SR device trial.

Information that the IRB must review in making the determination between SR and NSR include the following (which should be provided with the initial protocol submission):

- Reports of prior investigations conducted with the device
- The proposed investigational plan
- Subject selection criteria
- Monitoring procedures planned for the study
- Sponsor’s risk assessment and rationale
- Sponsor’s statement detailing any other IRBs that have reviewed the proposed study and what determinations were made.
• Sponsor’s statement regarding any assessments of the device’s risk that may have been made by the FDA.

The IRB’s risk determination is based upon the proposed use of a device in an investigation and not the device alone. Factors that must be considered by the IRB when evaluating the risk of a device include:

• The nature of the harm that may result from the device
• Is the potential harm to subject’s life threatening?
• Could the potential harm to subjects result in permanent damage to or impairment of body structure or function?
• Could the use of the device necessitate medical or surgical intervention to prevent damage to body structure or function?
• If the subject must undergo a procedure as a part of the investigation study, e.g., a surgical procedure, the IRB must consider the potential harm from the procedure in addition to the potential harm of the device.

The FDA makes the ultimate decision in determining if a device study is SR or NSR. If it does not agree with IRB’s decision that a device study presents an NSR, and IDE application must be submitted to the FDA. Likewise, if a sponsor or Investigator requests an IDE from the FDA for a presumed SR device study, but the FDA classifies the study as NSR, the IDE application will be returned and the Investigator should resubmit the study to the IRB as an NSR with the returned application.

Investigator's Responsibilities Related To Investigational Devices

21 CFR 812.110 states that Investigators may not obtain informed consent for the use of a device without first obtaining IRB and FDA approval. Investigators must assure that the device is placed under their direct supervision and supplied only to persons authorized to receive the device. If there is not a sponsor for an Investigational Device study, the Principal Investigator will be responsible for the internal monitoring and reporting functions of sponsors as listed in 21 CFR 812. The Investigator is also responsible for the control, disposal and record keeping related to investigational devices. Investigators are also responsible for maintaining the case histories of the subjects involved in investigational device trials. Investigational devices may not be used outside the supervision of the Investigator.

Sponsor-Investigator’s Responsibilities Related To Investigational New Drugs

It is the policy of the University of Arkansas for Medical Sciences (UAMS) Institutional Review Board (IRB) that all studies involving investigational drugs, agents, and/or biologics be reviewed and approved for use in accordance with Federal regulations and Institutional policies.

The IRB has the responsibility to evaluate all studies submitted by a Sponsor-Investigator, which involve the use of a drug substance, for compliance with 21 CFR 312, Investigational New Drug Application. There are at least three possible scenarios:
A. The Sponsor-Investigator already has applied for and/or received an IND under 21 CFR 312;

B. The Sponsor-Investigator has obtained a waiver of IND requirements from the FDA under 21 CFR 312.10; or

C. The Sponsor-Investigator has not determined the need for an IND for the study.

Sponsor-Investigator Responsibilities

A. IND Is Not Required

No further documentation is required of the Sponsor-Investigator; the ORC will issue a letter to the IRB.

B. IND Waiver

If the Sponsor-Investigator has already obtained a Waiver for 21 CFR 312, the FDA letter granting the waiver must be submitted to the IRB. If they have not yet applied for a waiver, they must inform the IRB of their intent and submit the letter granting or denying the waiver to the IRB. If the waiver is denied, the Sponsor-Investigator must either apply for an IND as outlined in this document or withdraw the protocol from consideration by the IRB.

C. IND Required

1. The Investigator will work with the ORC to develop an IND for submission to the FDA.

2. The Sponsor-Investigator will provide the IRB with a copy of the FDA Acknowledgement Letter when received.

3. The Sponsor-Investigator will notify the IRB and ORC when the 30-day waiting period is completed or if an FDA clinical hold has been placed on the IND.

4. The Sponsor-Investigator will develop and institute Standard Operating Procedures (SOPs) for the conduct of the clinical investigation. Assurance will be given to the ORC that these SOPs are in place and an index of said SOPs will be submitted to the ORC.

5. The Sponsor-Investigator will develop an IND monitoring plan (IRB Policy 7.8) and submit it to the IRB for their review and approval.

6. The Sponsor-Investigator will consult with the Research Pharmacist to develop a cost impact statement, dispensing, control, and handling of the drug.

7. The Sponsor-Investigator will consult with the ORC regarding the cGMPs and/or the cGTPs where applicable, and the GCPs.
Studies Of Devices With The FDA 510 K Designation

FDA regulations allow a manufacturer/sponsor to claim that a new device is substantially equivalent to models that FDA has already approved for marketing. Safety and efficacy testing of 510K devices, or use of 510K devices in clinical protocols, requires review by the IRB and approval before the study may begin. Application to the IRB should include verification of the device's 510K status.

Emergency Use Of Investigational Devices

If, in the opinion of the Investigator, a situation exists where an investigational device is required to protect the life or physical well being of a subject in an emergency, outside of the investigational trial, the Investigator should contact the IRB Chairperson and request emergency acknowledgment. Emergency Use of Investigational Devices should be reported in writing to the sponsor and the IRB immediately by the Investigator. Ideally, communication with the sponsor and the IRB should occur before any test article is used outside of the research context. If the Investigator is the sponsor, he/she is required to notify the FDA of the emergency use within 5-working days of the event.

Humanitarian Use Devices (HUD) Or Custom Devices

Investigators who wish to use devices classified by the FDA as Custom or Humanitarian Use should consult the IRB office for guidance before using such a device or submitting a protocol.

Investigational Devices That May Be Eligible For Exemption

Some investigational devices are exempt from the FDA regulations. These included certain diagnostic devices, minor modifications of marketed devices or custom devices. Investigators should request guidance from the IRB if unsure of the device status before use.

All devices, including those exempt from FDA regulations, require review and approval by the IRB before use in patients or subjects.
CHAPTER 12

Research Involving Vulnerable Populations

Certain groups of human subjects are considered to be particularly vulnerable to coercion or undue influence in a research setting. These groups and their special attention during the research process are outlined in 45 CFR 46.111(b) and 21 CFR 56.111(b). The regulations identify additional requirements for review and approval of research involving fetuses, pregnant women, and human *in vitro* fertilization, 45 CFR 46 Subpart B, prisoners, 45 CFR 46 Subpart C, and children, 45 CFR 46 Subpart D.

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Other Potentially Vulnerable Populations

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Illiterate English Speaking Subjects

Employees as Subjects

Students as Subjects
Non-English-Speaking Subjects
Terminally Ill Subjects
Research in Nursing Homes
Background Information

The following groups of human subjects are considered Vulnerable Populations:

- Children
- Wards of the State
- Prisoners
- Pregnant Women and Fetuses
- Persons Who Are Mentally Disabled or Otherwise Cognitively Impaired
- Other Potentially Vulnerable Populations:
  - Minorities
  - Economically or Educationally Disadvantaged Subjects
  - Illiterate English Speaking Subjects
  - Employees as Subjects
  - Students as Subjects
  - Non-English-Speaking Subjects
  - Terminally Ill Subjects

In reviewing research projects involving all categories of vulnerable subjects, the IRB must ascertain that their use is adequately justified and that additional safeguards are implemented to minimize risks unique to each group. A summary of the additional requirements for review and approval of research involving children, prisoners, and pregnant women and fetuses is presented below.

Research Involving Children

To safeguard their interests and to protect them from harm, special ethical and regulatory considerations apply for reviewing research involving children. The IRB may approve research involving children only if special provisions are met in addition to the other criteria required for approval. The IRB must classify research involving children into one of four categories and document their discussions of the risks and benefits of the research study. For more information, see IRB Policy 17.1 (Children in Research).

Federal regulations (Title 45 CFR 46, Subpart D) require that Investigators explicitly address the measures taken to protect the rights and welfare of children participating in protocols.

- Definition of Children

"Children" are defined as "persons who have not attained the legal age for consent to treatments or procedures involved in the research, under the applicable law of the jurisdiction in which the research will be conducted." 45 CFR 46.402(a).
In Arkansas, children includes all those who have not yet reached their 18th birthday and have not been legally emancipated. Emancipation may be obtained through judicial decree or based upon certain events such as marriage or military service. Marriage or military service does not automatically emancipate an individual and Investigator’s should seek guidance per Policy 1.6 if the issue arises.

Investigators submitting proposals to the NIH for human subject research must include children in the study unless there are scientific or ethical reasons not to include them. The proposals must specifically include a description of plans for including children. And, if children will be excluded, the application must present an acceptable justification for the exclusion. Investigators should review the NIH Policy and Guidelines before submitting their proposals.

National Institutes of Health (NIH) Policy and Guidelines on the Inclusion of Children as Participants in Research Involving Human Subjects (March 6, 1998)

Categories of Research Involving Children

45 CFR 46, Subpart D, classifies research involving children into one of four categories depending upon the risks and benefits of the proposed research, which can be approved as follows:

<table>
<thead>
<tr>
<th>CATEGORY OF RISK TO THE CHILD</th>
<th>CONSENT REQUIREMENTS</th>
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<tbody>
<tr>
<td>Pediatric Risk Category I:</td>
<td></td>
</tr>
<tr>
<td>Minimal Risk</td>
<td>One parent/guardian permission</td>
</tr>
<tr>
<td>Pediatric Risk Category II:</td>
<td></td>
</tr>
<tr>
<td>Greater than minimal risk, but presenting the prospect of direct benefit to individual participants</td>
<td>One parent/guardian permission</td>
</tr>
<tr>
<td>Pediatric Risk Category III:</td>
<td></td>
</tr>
<tr>
<td>Greater than minimal risk and no prospect of direct benefit to individual participants but likely to yield important generalizable knowledge about the participant’s disorder or condition.</td>
<td>Both parents’ permission, unless one is not reasonably available, deceased, unknown, legally incompetent, or does not have legal responsibility for care of the child.</td>
</tr>
<tr>
<td>Pediatric Risk Category IV:</td>
<td></td>
</tr>
<tr>
<td>Otherwise not approvable, but presents an opportunity to understand serious health or welfare problems of children</td>
<td>Generally not approved, requires a panel of experts</td>
</tr>
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</table>
Pediatric Risk Category I: Research Not Involving More Than Minimal Risk. When the IRB finds that no greater than minimal risk to children is present, the IRB may approve the proposed research only if the IRB finds that adequate provisions are made for soliciting the assent of the children and the permission of their parents or guardians, as set forth below.

Pediatric Risk Category II: Research Involving Greater than Minimal Risk but Presenting the Prospect of Direct Benefit to the Individual Subjects. If the IRB finds that more than minimal risk to children is present by an intervention or procedure but that the intervention or procedure holds out the prospect of direct benefit for the individual subject, or by a monitoring procedure that is likely to contribute to the subject's well-being, the IRB may approve the research only if the IRB finds that:

1. The risk is justified by the anticipated benefit to the subjects;
2. The relation of the anticipated benefit to the risk is at least as favorable to the subjects as that presented by available alternative approaches; and
3. Adequate provisions are made for soliciting the assent of the children and permission of their parents or guardians, as set forth below.

Pediatric Risk Category III: Research Involving Greater than Minimal Risk and No Prospect of Direct Benefit to Individual Subjects, but Likely to Yield Generalizable Knowledge about the Subject's Disorder or Condition. If the IRB finds that more than minimal risk to children is presented by an intervention or procedure that does not hold out the prospect of direct benefit for the individual subject, or by a monitoring procedure which is not likely to contribute to the well being of the subject, the IRB may approve the research only if the IRB finds that:

1. The risk represents a minor increase over minimal risk;
2. The intervention or procedure presents experiences to subjects that are reasonably commensurate with those inherent in their actual or expected medical, dental, psychological, social, or educational situations;
3. The intervention or procedure is likely to yield generalizable knowledge about the subjects' disorder or condition which is of vital importance for the understanding or amelioration of the subjects' disorder or condition; and
4. Adequate provisions are made for soliciting assent of the children and permission of their parents or guardians, as set forth below.

Pediatric Risk Category IV: Research Not Otherwise Approvable Which Presents an Opportunity to Understand, Prevent, or Alleviate a Serious Problem Affecting the Health or Welfare of Children. If the IRB does not believe the research proposal meets any of the requirements set forth above, it may still approve the protocol but only if:

1. The IRB finds that the research presents a reasonable opportunity to further the understanding, prevention, or alleviation of a serious problem affecting the health or welfare of children; and
2. The Secretary of the Department of Health and Human Services or The Commissioner of Food and Drugs, as applicable, after consultation with a panel of experts in pertinent
disciplines (for example: science, medicine, education, ethics, law) and following opportunity for public review and comment, has determined either that the research in fact meets one of the categories set forth above, or all of the following:

a. The research presents a reasonable opportunity to further the understanding, prevention, or alleviation of a serious problem affecting the health or welfare of children;

b. The research will be conducted in accordance with sound ethical principles; and

c. Adequate provisions are made for soliciting the assent of children and the permission of their parents or guardians, as set forth below.

Investigators should:

1.1 Design research projects involving children in accordance with this policy, making provisions to obtain the assent of all children over the age of 7. If the study population is such that the children will not be able to provide assent at the age of 7 or at all, the Investigator should specify this in the assent provisions of the application.

1.2 Identify in ARIA the pediatric category of research that the Investigator feels the project best meets and upload permission and/or assent documents.

-Assent of Children

“Assent “ means a child’s affirmative agreement to participate in research. A child who fails to object to participation is not necessarily assenting to participation. Assent is not passive. “Permission” is the agreement of parent(s) or guardian to the participation of their child or ward in research.

The IRB must determine for all studies involving children

- The age of subjects where assent is required
- How and at what age assent is to be documented

Assent must be accompanied by the signed informed consent of the parent (parents) or legal guardian of the child. The Investigator must also inform the child of the purpose and the voluntary nature of their participation. This must be modified to the child’s age and ability to comprehend. The following are guidelines for age ranges in obtaining assent from children. These guidelines are recommended and are not intended to replace any institutional policies and procedures regarding the assent of children.

- Children younger than 7 years of age:

If appropriate as determined by the child’s age and cognitive development, the Investigator should administer a simple oral explanation of the study procedures to be conducted.

- Children 7 years of age and less than 18 years of age:

Written assent must be obtained from the child if it is an IRB requirement. Assent of a child should be obtained in the presence of a parent/legal guardian and witness.
The IRB encourages the Principal Investigator to submit classification information related to the study’s risk category, age required for assent and method of assent documentation in the initial study submission packet.

The IRB’s purpose is not to demand adherence to rigid criteria based solely on age, but to use the age ranges above as guidelines for approaching children after taking into account their emotional and cognitive development. For all children, but especially those with developmental disorders, the age ranges listed above refer to the cognitive rather than the chronological age.

The IRB reserves the right to require both parents’ permission on selected protocols if the committee waives child assent or if additional requirements from the PI are deemed necessary by the convened IRB. The IRB may consider a request from that PI that the permission of one parent is sufficient for research involving greater than minimal risk, if there is a clear prospect of direct benefit to the child-participant.

The requirements of parental permission may be waived in those cases where it is clear that the parents’ interests do not adequately reflect the child’s interests (e.g., research on child abuse or neglect). These research protocols require Investigators to develop special procedures, which must be approved by the convened IRB that protects the rights and welfare of the children asked to participate.

There are NO exemptions for Research Involving Children’s Participation in Surveys or Interviews

Unlike research involving adults, the exemption at 45 CFR 46.101(b)(2) for research involving survey procedures, interviews, educational tests, or public observations (except where the Investigator does not participate in the activities being observed) does not apply to research involving children. 45 CFR 46.401(b).

 avalia Child Abuse Reporting

The State of Arkansas requires the reporting of suspected child abuse or neglect. Investigators must abide by this law. If the protocol involves interviewing children about topics that might lead to a suspicion or to knowledge on the part of the Investigator of child abuse or neglect, the child (and parent or guardian) must be informed of the reporting requirement as part of the informed consent process.

The following sentence(s) should be integrated into the currently required Informed Consent Document among the statements about confidentiality and its limits:

“We will attempt to maintain the confidentiality of any information you/your child give us in the course of this study. However, you should be aware of limits to the confidentiality of your information.”

“The researcher may also be required to report any child abuse or any intention you have to hurt yourself or others. The researcher, if ordered to do so by a court of law, may be required to disclose information you have provided.”
❖ Wards of the State

Children who are wards of the state or any other agency, institution, or entity can be included in IRB research only if the IRB finds and documents that such research is: (1) related to their status as wards; or (2) conducted in schools, camps, hospitals, institutions, or similar settings in which the majority of children involved as subjects are not wards.

If the research is approved, the IRB must require appointment of an advocate for each child who is a ward, in addition to any other individual acting on behalf of the child as guardian. One individual may serve as advocate for more than one child. The advocate shall be an individual who has the background and experience to act in, and agrees to act in, the best interests of the child for the duration of the child's participation in the research and who is not associated in any way (except in the role as advocate or member of the IRB) with the research, the Investigator(s), or the guardian organization.

A foster parent may NOT give permission for a ward of the state to participate in research. Such permissions must be obtained through the Arkansas Department of Human Services.

❖ Emancipated Minors

There are exceptions to the rule of obtaining assent and seeking parental permission for individuals considered emancipated minors by the state of Arkansas. "Emancipated minors" may include individuals under the age of 18, living on their own and financially independent from their parent or legal guardian, have borne a child, or are married. Consent is sought from an emancipated minor; not assent.

❖ Research Involving Prisoners

❖ Prisoners in Research

The special vulnerability of prisoners makes consideration of involving them as research subjects particularly important. Prisoners may be under constraints because of their incarceration, which could affect their ability to make a truly voluntary and uncoerced decision whether or not to participate as subjects in research. To safeguard their interests and to protect them from harm, special ethical and regulatory considerations apply for reviewing research involving prisoners.

Therefore, if a protocol involves the use of prisoners as subjects, or a subject becomes incarcerated after enrollment, both the general IRB Policies apply and the special ones outlined in this Policy apply. The IRB may approve research involving prisoners only if these special provisions are met.

 Expedited Review of Research Involving Prisoners Not Allowed. The full IRB Committee must review research involving prisoners as human subjects.

Exemption from Review of Research Involving Prisoners Not Allowed. Research that would otherwise be exempt from the requirement that it receive IRB approval is not exempt when the research involves prisoners.
Applicability of Policy Providing Special Protections for Prisoners. This policy applies to anyone using the UAMS IRB as the IRB of record and any personnel subject to UAMS oversight in research involving prisoners.

Research involving prisoners does not qualify for exemption from IRB review. For more information, see IRB Policy 17.9, Prisoners in Research.

- **Categories Of Research Involving Prisoners [45 CFR 46.306(a)]**
  
  - Studies regarding the possible causes, effects, and processes of incarceration, and of criminal behavior, provided that the study presents no more than minimal risk and no more than inconvenience to the subjects.
  
  - Studies of prisons as institutions, or of prisoners as incarcerated persons, if those studies present no more than minimal risk or inconvenience to the subjects.
  
  - Research on conditions affecting prisoners as a class after HHS publishes a notice in the federal register.
  
  - Research on practices that are intended, and reasonably likely, to enhance the well-being of the subjects; however, if some of the prisoners will be assigned to control groups which will not benefit from the research, then the study must first be approved by HHS.

In addition to the general requirements for review, in reviewing prisoner research, IRBs are required by 45 CFR 46.305(a) to ensure that:

- The membership of the IRB reviewing the protocol includes a prisoner or a prisoner representative with appropriate background and experience to serve in that capacity, and that the majority of the IRB is not associated with the penal institution involved. If no current member of the IRB meets the prisoner or prisoners' representative criteria, then the IRB Chair will identify and recruit a qualified individual to fulfill this requirement and advise the IRB. In addition, a majority of the IRB members at the meeting must not be associated with the prison.

- Any advantages that prisoners will realize as a result of participating in the research, when compared to the general living conditions within the prison, are not so great as to impair prisoner's ability to weigh the risks and benefits of participation and freely choose whether to participate.

- The risks involved in the research are commensurate with risks that would be accepted by non-prisoner volunteers.

- Procedures for selecting subjects to determine are fair, and free from arbitrary manipulation by prison authorities or prisoners.

- Control subjects will be selected randomly from among the group of eligible volunteers, unless the PI justifies a different procedure.

- The information presented during the recruitment and consent procedures to ensure that it is in a language, and level of complexity, that is understandable to the subject population.
• The parole board will not take participation in the study into account, and that each prisoner will be informed that participation will have no effect on parole.

• Adequate provision will be made for follow-up care as necessary.

In addition, the FDA imposes specific restrictions on the use of prisoners in research involving FDA-regulated products. Use of prisoners in these studies is prohibited unless the specific requirements of this section are met (21 CFR 50, Subpart C). When an IRB reviews research falling within this category, its assurance provides for OHRP to be notified that the above criteria have been met.

### Prisoner Research Update

On June 20, 2003, the following information concerning research involving prisoners was published in the [Federal Register](https://federalregister.gov): Certain parts of 45 CFR 46 Subpart C were waived by DHS to allow DHHS to conduct or support certain important and necessary epidemiologic research on prisoners that presents no more than minimal risk and no more than inconvenience to the prisoner subjects. The Secretary of DHHS specifically proposed waiving the applicability of 45 CFR 46.305(a)(1) and 46.306(a)(2) for certain research conducted or supported by DHHS that involves epidemiologic studies that meet the following criteria:

1. **In which the sole purposes are**
   1. To describe the prevalence or incidence of a disease by identifying all cases, or
   2. To study potential risk factor associations for a disease, and
2. **Where the institution responsible for the conduct of the research certifies to the Office for Human Research Protections, DHHS, acting on behalf the Secretary, that the IRB approved the research and fulfilled its duties under 45 CFR 46.305(a)(2)–(7) and determined and documented that**
   1. The research presents no more than minimal risk and no more than inconvenience to the prisoner-subjects, and
   2. Prisoners are not a particular focus of the research.

The specific type of epidemiological research conducted or supported by DHHS and subject to the waiver involves no more than minimal risk and no more than inconvenience to the human subject participants. The proposed waiver would allow DHHS to conduct or support a type of minimal risk research that does not now fall within the categories set out in 45 CFR 46.306(a)(2).”

The range of studies to which the proposed waiver applies includes epidemiological research related to chronic diseases, injuries, and environmental health. This type of research uses epidemiologic methods (such as interviews and collection of biologic specimens) that generally entail no more than minimal risk to the subjects.

### Minimal Risk Definition For Prisoner Research and Non-Prisoners

The federal regulations list a different definition of minimal risk for prisoners in research from non-prisoners in research. The following information is from the [OHRP Guidance on the Involvement of Prisoners in Research](https://www.hhs.gov/ohrp) dated May 23, 2003:
**Definition of Minimal Risk in Prisoner Research** 45 CFR 46.303(d) | **Definition of Minimal Risk in 45 CFR part 46, subpart A, 45 CFR 46.102(i) (Non-Prisoners)**
---|---
"Minimal risk" is the probability and magnitude of **physical** or **psychological** harm that is normally encountered in the daily lives, or in the routine medical, dental, or psychological examination of **healthy persons.**” | "Minimal risk means that the probability and magnitude of harm or discomfort anticipated in the research are not greater in and of themselves than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests."

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Do not enroll a prisoner in an ongoing, IRB approved study without the approval of the committee. If a study subject becomes a prisoner during the course of the research, notify the IRB immediately.

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❖ **Research Involving Pregnant Women And Fetuses**

45 CFR 46 Subpart B, provides additional protections for research involving pregnant women. Pregnant women should not be excluded from research as participants if the risk to the fetus is minimal. If pregnant women are included in a research protocol, the informed consent must address the research activity and its possible impact on the fetus.

Researchers should obtain informed consent from both the pregnant woman and the father of the fetus. Consent by the father is not necessary if:

- The purpose of the study is to meet the health needs of the mother.
- The identity or whereabouts of the father cannot be reasonably ascertained.
- The father is not reasonably available.
- The pregnancy is the result of rape.

Research targeting pregnant women as subjects cannot qualify for an exemption.

❖ **Research Involving Cognitively Impaired Individuals**

The participation of cognitively impaired individuals in research typically falls in categories that cannot be reviewed using exempt procedures. In addition, projects involving cognitively impaired individuals must specifically address how an individual’s capacity to give informed consent will be determined. *Examples of cognitive impairment include: diagnosed mental retardation, dementia, and coma.*

The IRB is not in a position to determine if an individual identified with a cognitive impairment has the capacity to give informed consent.

CAVHS permits the use of a surrogate consent process for persons who are cognitively impaired.

The IRB advises the use of the decision algorithm when it is unclear if cognitive impairment may prevent a subject from giving informed consent.

For more information, see [IRB Policy 17.2 (Cognitively Impaired Persons)](#).
Lawgically Authorized Representatives (LARS)

In Arkansas, in addition to other persons as may be authorized and empowered, the legally authorized representative for another person, for purposes of providing consent for research involving surgical or medical treatments or procedures, not prohibited by law, which might be suggested, recommended prescribed or directed by a licensed physician, is any one the following:

1. Any parent, whether an adult or a minor, for his minor child or adult child of unsound mind. Child as used here includes biological, adopted, step or foster children. The father of an illegitimate child, however, cannot consent for the child solely on the basis of parenthood;
2. Any person standing in loco parentis, whether formally serving or not;
3. Any guardian, conservator, or custodian, for his ward or other charge under disability;
4. Any adult for a minor sibling or adult sibling of unsound mind;
5. If an authorized parent is absent, any maternal grandparent and, if the father is an authorized parent, any paternal grandparent, for a minor grandchild or for an adult grandchild of unsound mind;
6. Any married person, for a spouse of unsound mind; or
7. Any adult child, for their mother or father of unsound mind.

For more information, see IRB Policy 17.13 (Legally Authorized Representatives). Note VA has different rules, see IRB Policy 17.2.

Other Potentially Vulnerable Populations

- Economically or Educationally Disadvantaged Subjects

For research involving economically disadvantaged subjects, special care must be taken to assure that the financial inducements offered do not constitute the sole grounds for the subject participation in the research protocol. Financial inducements should also not be used to assume risks that subjects would not ordinarily incur.

The consent form for research involving educationally disadvantaged subjects should be written with special attention to assure that terminology has been sufficiently simplified. The Investigator should discuss orally every aspect of the study with the subjects to insure their understanding.

- Illiterate English Speaking Subjects

An Investigator in an IRB approved study may enroll individuals who can speak and understand English, but cannot read or write. The potential subject must be able to place a written mark on the consent form.

The subject must also be able to:

- Comprehend the concepts of the study and understand the risks and benefits of the study as it is explained verbally, and
- Be able to indicate approval or disapproval for study enrollment.
If an Investigator uses the above method to obtain consent, there must be documentation on the subject’s consent form specifying what method was used to communicate the information and the specific means that the subject communicated agreement to study participation.

- **Employees as Subjects**

Employees may be recruited as study subjects. However, Investigators should avoid using their own employees as research participants because of potential coercion and undue influence. The preferred method of recruiting employees for research studies is notices on institutional bulletin boards or third party notification, e.g. word of mouth. No directed advertising among one’s own employees should be used. Recruitment notices, including bulletin board or newspaper ads, are to be submitted to the IRB before they are posted or submitted for publication.

- **Students as Subjects**

Recruiting students as subjects represents a potential problem for Investigators. Possible coercion is an issue from a student participating in a study conducted by his or her advisor. Undue influence is an issue whenever a student’s participation will be made known to someone who holds power over his or her academic status. How the Investigator plans to handle potential problems of coercion and undue influence must be addressed in the initial submission of the study to the IRB. In particular, activities that involve students who report directly to the Investigator or attend a class for which the Investigator has responsibility must be described.

- **Non-English-Speaking Subjects**

Non-English-Speaking subjects may not be excluded from therapeutic studies on the basis of language use if there is a possibility that they might benefit by participating in the study. If a research subject does not understand English, the informed consent document should be in the language readily understood by the subject to meet the requirements of 21 CFR 50.20. If the principal Investigator anticipates that consent interviews will be routinely conducted in a language other than English, the IRB requires a translated consent document be submitted with the original protocol for approval. It is the Investigator’s responsibility to ensure that the translation is accurate.

As required by 21 CFR 50.27, a copy of the consent document must be given to each subject. While a translator may be helpful in facilitating conversation with a Non-English-Speaking subject, verbal translation of the consent document must not be substituted for a written translation.

If a Non-English-Speaking subject is unexpectedly encountered, see [IRB Policy 15.4, Non-English-Speaking Research Subjects](#).
Terminally Ill Subjects

From the Office of Human Research Protections (OHRP) IRB Guidebook:

Terminally ill patients are those who are deteriorating from a life-threatening disease or condition for which no effective standard treatment exists. It is generally considered unacceptable to ask such persons to participate in research for which alternative, not similarly burdened, populations of subjects exist. Nevertheless, it may often be necessary to involve terminally ill patients in research concerning their disease and its treatment. Further, terminally ill persons should not be excluded from research in which they may want to participate simply because of their status. One can imagine that altruism and a desire to bring good from adversity may well motivate persons suffering from life-threatening illnesses to become involved in biomedical or behavioral research. Still, terminally ill individuals are a vulnerable population of research subjects, and, therefore, require additional protection against coercion and undue influence.

\[45 \text{ CFR 46.111(b)}\]

The risk of coercion and undue influence may be caused by a variety of factors. In addition to the fact that severe illness often affects a person's competence, terminally ill patients may be vulnerable to coercion or undue influence because of a real or perceived belief that participation is necessary to receive continuing care from health professionals or because the receipt of any treatment is perceived as preferable to receiving no treatment. Although terminally ill patients should be protected from an understandable tendency to enroll in research under false hopes, IRBs should not take too protective an attitude toward competent patients simply because they are terminally ill. Some terminally ill patients may find participation in research a satisfying way of imparting some good to others out of their own misfortune.

It is important to distinguish between risks that may be justified by anticipated benefits for the research subjects and risks associated with procedures performed purely for research purposes. A particularly difficult issue relating to research involving terminally ill patients arises in connection with the conduct of Phase 1 drug trials in which the drugs involved are known to be particularly toxic (e.g., a new form of cancer chemotherapy). In some of these studies, any benefit to the subject is, at best, highly unlikely. Despite the "therapeutic intent" of the Investigators to benefit the subject, subjects may in fact experience a decline in health status, no improvements in terms of quality of life, or lengthened life for only a short time. It is extremely important that prospective subjects be clearly informed of the nature and likelihood of the risks and benefits associated with this kind of research. The challenge to the Investigator and the IRB is to provide patients with an accurate description of the potential benefits without engendering false hope.
Research in Nursing Homes

Aside from the regulatory requirement that IRBs provide additional protections for specially vulnerable persons, there are no specific regulations governing research with elderly subjects. The elderly are, as a group, heterogeneous and not usually in need of special protections, except in two circumstances: cognitive impairment and institutionalization. Under those conditions, the same considerations are applicable as with any other, non-elderly subject in the same circumstances. See IRB policy 17.2 for discussion of cognitive impairment.

Institutionalization: In the past, persons in nursing homes or other institutions have been selected as subjects because of their easy accessibility. However, conditions in institutional settings increase the chances for coercion and undue influence because of the lack of freedom inherent in such situations. Research in these settings should therefore be avoided, unless the involvement of the institutional population is necessary to the conduct of the research (e.g., the disease or condition is endemic to the institutional setting, persons who suffer from the disease or condition reside primarily in institutions, or the study focuses on the institutional setting itself).

IRB Considerations: When a research study is undertaken at a nursing home, all necessary parties are informed and all documentation is maintained in a manner that meets all local, state, and federal research requirements.

For more information, see IRB Policy 17.4 (Subjects in Long Term Care).
CHAPTER 13

Payment/Reimbursement of Research Subjects

This section concerns the payment and reimbursement of research subjects.

Subject Compensation
Recruitment of Study Subjects
Billing Of The Research Subject at UAMS
Billing For Research Activities
Subject Compensation

Compensation or payment to research subjects for participation in studies is not considered a benefit. Rather, it should be considered compensation for time and inconvenience. The amount and schedule of all payments should be presented to the IRB at the time of initial review.

1. **Timing of Payments.** Credit for payment should accrue as the study progresses and not be contingent upon the subject completing the entire study. The subject should be paid in proportion to their time and inconvenience as a result of participation in the research study. Unless it creates undue inconvenience or a coercive practice, payment to subjects who withdraw from the study may be paid at the time they would have completed the study (or completed a phase of the study) had they not withdrawn. For example, in a study lasting only a few days, an IRB may find it permissible to allow a single payment date at the end of the study, even to subjects who had withdrawn before that date.

2. **Completion Bonus.** While the entire payment should not be contingent upon completion of the entire study, payment of a small proportion as an incentive for completion of the study is acceptable, providing that such incentive is not coercive. The IRB will determine whether the amount paid as a bonus for completion is reasonable and not so large as to unduly induce subjects to stay in the study when they would otherwise have withdrawn.

3. **Disclosure of Payments.** All information concerning payment, including the amount and schedule of payment(s) should be set forth in the informed consent document.

4. **Advertisement of Payments.** Advertisements may state that subjects will be paid or compensated, but should not emphasize the payment or the amount to be paid, by such means as larger or bold type.

Alterations in Payments. Any alterations in human research subject payment or liberalization of the payment schedule must be reported to the IRB prior to implementation as an amendment.

VA Research Participants: VA policy prohibits paying human subjects to participate in research when the research is integrated with a patient’s medical care and when it makes no special demands on the patient beyond those of usual medical care. Payment may be permitted, with IRB approval, in the following circumstances:

1. **No Direct Subject Benefit.** When the study to be performed is not directly intended to enhance the diagnosis or treatment of the medical condition for which the volunteer subject is being treated, and when the standard of practice in affiliated non-VA institutions is to pay subjects in this situation.

2. **Others Being Paid.** In multi-institutional studies, when human subjects at a collaborating non-VA institution are to be paid for the same participation in the same study at the same rate proposed.
(3) **Comparable Situations.** In other comparable situations in which, in the opinion of the IRB, payment of subjects is appropriate.

(4) **Transportation Expenses.** When transportation expenses are incurred by the subject that would not be incurred in the normal course of receiving treatment and which are not reimbursed by any other mechanism.

**VA Investigators** who wish to pay research subjects must in their proposal:

1. Substantiate that proposed payments are reasonable and commensurate with the expected contributions of the subject;
2. State the terms of the subject participation agreement and the amount of payment in the informed consent form; and
3. Substantiate that subject payments are fair and appropriate, and that they do not constitute (or appear to constitute) undue pressure or influence on the perspective research subjects to volunteer for, or to continue to participate in, the research study; and that the payments do not constitute (or appear to constitute) coercion to participate in, or continue to participate in, the research study.

The IRB will review both the amount of payment and the proposed method and timing of disbursement to assure that neither are coercive nor present undue influence.

Each institution (ex. UAMS, CAVHS and ACH/ACHRI) has its own policies regarding the appropriate handling of payments to research subjects. The PI is responsible for following the appropriate policies.

**Recruitment of Study Subjects**

The UAMS IRB is responsible for ensuring the equitable selection of research participants with the proper safeguards in place to protect the rights and welfare of the participants. In fulfilling this responsibility, the UAMS IRB will review the methods and materials that investigators use to recruit subjects.

No matter the method chosen to identify potential research participants, provisions must be in place to protect the individual’s right to privacy.

Contacting primary care providers (PCP) for access to potential participants from the patient population of the PCP is another method of potential recruitment. This would require IRB approval prior to initiation and the PCP may be subject to HIPAA restraints that would prevent him/her from sharing PHI with the Investigator.

Searching Medical Records or other Databases of Patient information looking for potential participants requires IRB approval prior to the search. (NOTE: A search to find out if a patient population exists in anticipation of a research project would not be considered recruitment provided no identifying information was retained to be used later.)
1. Advertising for research subjects. When advertising is to be used, the UAMS IRB will review the information contained in the advertisement, and the mode of its communication, to determine that the procedure for recruiting subjects affords adequate protection. Advertisements used to recruit subjects should be seen as an extension of the informed consent and subject selection processes. Therefore, the UAMS IRB will review all advertisements to ensure that the information is not misleading to subjects, especially when a study will involve persons with acute or severe physical or mental illness or persons who are economically or educationally disadvantaged.

Generally, any advertisement; print, electronic or other media, to recruit subjects should be limited to:

1. The name and address of the clinical investigator and/or the research facility
2. The purpose of the research and that it is in fact research
3. The eligibility criteria that will be used to admit subjects to the study
4. A straightforward and truthful description of the benefits or burdens (e.g., reimbursements, no cost treatment, placebo control) to the subject for participating in the study
5. The time or other commitment required from the subject
6. The location of the research and the person to contact for further information

Advertisements, regardless of form, may not:

1. Be Misleading or Coercive either in wording or visual effects
2. Promise a Favorable Outcome
3. Promise “Free Medical Treatment” if the intent is simply that there is no charge to partake in the research project.
4. Imply any benefits beyond what is outlined in the consent and protocol
5. Use terms such as “New Treatment”, “New Drug”, “New Medication” without explaining that the test article is investigational
6. Emphasize amount of payment for participation
7. Make claims, either explicitly or implicitly, that a drug or device is safe or effective for the purposes under investigation, or that the drug or device is in any way equivalent or superior to any other drug or device.

❖ Billing Of The Research Subject at UAMS

Principal Investigators are required to follow the policies and procedures of the institution when billing research and clinical costs. At UAMS, the PI is to follow the policy “Billing for Research Procedures”. All efforts should be made to assure that research subjects are billed in a correct and ethical manner. Consent forms should clearly differentiate what costs the subject will be responsible for and what costs the study will pay.

❖ Billing For Research Activities

Prior to submission of the protocol, make plans to establish correct billing procedures for research.
PURPOSE

The purpose of this section is to define the procedure of processing payment requests for research subjects that are not employees of the University of Arkansas for Medical Sciences. Payments to employees are processed through Human Resources and procedures are detailed on a separate Policy Statement.

PROCEDURE

1. For payments to non-employees that are individually less than $200 each, a Petty Cash Voucher is submitted to the Treasurer’s Office. This form lists names, addresses, amounts and fund/account/cost center numbers that will be charged in the General Ledger accounting system. The form must have the approval signature of an authorized departmental disbursing officer. Checks will be prepared and either released to departmental representatives or mailed directly to the research subjects. Payments to research subjects participating in projects requiring anonymity will also be processed through Petty Cash, with checks payable to an authorized departmental representative.

2. For IRS reporting purposes, payment requests for non-employees in amounts equal to or greater than $200 must be processed on a Purchase Requisition and sent to the Procurement Department. The social security number for each subject will be required information on the Purchase Requisition. For individuals receiving $600 or more during a calendar year, an IRS 1099 form will be sent to the individual subjects and reported to the IRS as taxable income.

3. If anticipated total payments to an individual research subject exceed $600, the department should process the payment request through Procurement on a Purchase Request, even if individual payments may be less than the $200 limit. This will allow the capture of information for 1099 reporting to the IRS.

For more information on payments to research subjects, see Policy 8.7.01 in the UAMS Administrative Guide.
CHAPTER 14

Educational Policies And Resources

This section concerns educational policies and resources.

Investigators And Study Staff

Training Links For Researchers Using UAMS IRB
Additional Training Links For Researchers At CAVHS
Training Policy
Investigators And Study Staff

IRB policy is that all Investigators desiring to engage in research using human subjects must familiarize themselves with IRB policies and procedures and related federal regulations. Investigators should maintain an on-going relationship with the IRB to gain assistance in following policies and procedures during the conduct of their studies. This will help assure that both Investigators and the IRB remain in compliance with all state and federal regulations regarding research involving human subjects.

Training Links For Researchers Using UAMS IRB

- Human Subject Protection Training – www.uams.edu/ORC
- HIPAA for Research Training – www.uams.edu/ORC

Additional Training Links For Researchers At CAVHS

- VHA Privacy Policy - http://www1.va.gov/resdev/fr/PRIDE/training/

Training Policy

For more information regarding UAMS education policy, see Policy Number 12.1.06 in the UAMS Administrative Guide.
CHAPTER 15

IRB Authority In Non-Compliance Issues

When the IRB is notified of events for which review is necessary by the convened IRB, the IRB chair or designated Chair will bring the issue to the attention of the IRB for appropriate action.

If the IRB is notified of events that indicate potential regulatory noncompliance, the committee will attempt to provide assistance through written contingencies to assist the Investigator with achieving compliance without the imposition of sanctions. However, in cases where Investigator cooperation does not occur and/or when it is determined that the safety or welfare of subjects or the integrity of the institution are or have been placed at risk, sanctions may be imposed.

Non-Compliance Issues

Study Closure

Reopening Of A Closed Study

Suspension

Termination

Appeals Procedures For IRB Actions
Non-Compliance Issues

The IRB has the regulatory authority to:

- Increase the frequency of continuing review
- Appoint a subcommittee of appropriately qualified IRB members to investigate alleged non-compliance issues and advise the convened IRB
- Suspend study approval until compliance is achieved
- Terminate individual research protocols
- Report specific non-compliance activities of the Investigator to appropriate governmental entities
- To request the UAMS Office of Compliance to perform a targeted review of study records and data

The IRB also has the regulatory authority to recommend additional sanctions to the Vice Chancellor for Academic Affairs and Research (VCAA/RA). These sanctions include:

- Research privilege probation
- Suspension of research privileges
- Termination of research privileges
- Embargo of publications.

The Principal Investigator will be notified in writing if the IRB is investigating non-compliance issues and may be requested to cease all accrual or all interaction with subjects. Following the investigation and subsequent deliberations of the IRB, the Investigator will be provided written findings with one of the following actions:

- The research may continue
- The research may continue after contingencies are satisfactorily addressed
- The research may not continue due to placement or recommendation of sanctions

The IRB is required to report to the Vice-Chancellor for Academic Affairs and Sponsored Research, institutional officials, sponsoring agencies, the US Office for Human Research Protections (OHRP) and grants management officers concerning any suspension or termination of research protocols. If the protocol involves drugs or devices, the IRB is also required to notify the Food and Drug Administration (FDA).

If the protocol involves the Veterans Administration, the IRB will also notify the VA R & D Committee and the Office for Research Oversight (ORO).

The IRB is also required to report to these agencies any unanticipated problems involving risks to subjects or others, and serious or continuing non-compliance as determined by the IRB [45 CFR Part 46.103(b) (5)].
The UAMS IRB, UAMS Office of Research Compliance and the UAMS Vice Chancellor for Academic Affairs (VCAA/RA) work cooperatively to assure compliance of all studies under the IRB’s review. Institutions other than UAMS who use the UAMS IRB also have assurance requirements for compliance.

All reports of alleged non-compliance or inappropriate involvement of humans in research will be investigated. Such reports may be received from any source by the UAMS IRB Staff, chair or members, the ORC, or the VCAA/RA. For more information on the process, see IRB Policy 12.4 (Non-compliance with Human Research Protection Program Requirements).

Study Closure

Study closure is a voluntary process and carries no punitive implications. Closure is not reported to institutional officials or to the department or agency head. Closure typically applies in the following situations:

- At the completion of the study (i.e., new enrollment is closed and all data collection and analysis are completed);
- If the Investigator chooses to close the study (e.g., the study has not met its enrollment goal, but the Investigator does not plan to enroll new subjects, collect additional data from enrolled subjects, or perform any additional data analysis);
- The Investigator leaves the institution and does not intend to transfer responsibility for the study to another Investigator.

The Investigator must request study closure. The IRB office must be notified when a study is completed. This notification should be sent when all participants have completed treatment and follow-up phases of the study and analysis is completed to the point that the participant’s records will no longer be needed. The Investigator must complete the Study Closure Form through ARIA that addresses the following:

- Protocol title and record number
- Name of PI
- Number of subjects accrued
- Number of subjects completing study
- Any publications that have resulted from data collected during the study
- Any adverse events that have not been previously reported.

The final report of study results should be received by the IRB within 30 days of decision to close a study. Investigators may request closure of a study upon continuing review or by submitting a separate study closure form.

If no subjects have been enrolled in the previous five years and all data collection is complete, the Investigator should close the study. Studies that are not closed properly by the PI may be terminated.
Re-opening Of A Closed Study

An Investigator may request that a closed study be re-opened within six months of that closure with a written request to the IRB and any updated information. After six months of closure or if updated information is significant, a new submission may be required.

Suspension

Suspension is a non-permanent interruption of research activities. Suspension may occur for the following reasons:

- Unexpected and serious adverse effects that significantly increase risks relative to benefits
- Evidence that an Investigator failed to adequately protect participants in a research study
- Willful or repeated failure to comply with federal regulations, state laws, or institutional rules that govern human research activities
- Proven research fraud or scientific misconduct
- At the request of institutional officials who have been charged with responsibility for oversight of research involving human subjects (e.g., the Chancellor or the Vice Chancellor for Academic Affairs and Research Administration).
- At the request of the study sponsor, the FDA, the Office for Human Research Protections, or other duly authorized regulatory or governmental department or agency head
- Any other reason deemed necessary by a simple majority vote of a convened IRB Committee (a quorum must be present)
- The IRB or the Investigator decides that new enrollment and risk-bearing activities should be interrupted pending an investigation into any problem or alleged problem with a particular study
- Any study may be suspended by majority vote of the IRB members at a convened meeting with a quorum present. A study that is suspended may be reopened without resubmission as a new protocol and consent form. If discontinuation of study-related therapy might result in increased risk of significant harm to an individual or a group of study subjects, the IRB reserves the right to permit continued therapy with an investigational drug, device, or biologic for subjects who are already enrolled in a treatment study. Enrollment of new subjects generally will not be permitted. However, at the request of the Investigator, the IRB Chair or a designee may permit enrollment into a suspended study if and only if there is no alternative therapy for a life-threatening condition.

At the time the study is suspended, the IRB will establish a unique and specific plan that, if completed, by the PI, will lead to re-review of the study resulting in a decision as to whether to continue or end the suspension or to terminate the study. An audit of the Investigator’s studies may be undertaken. As a minimum, the unique and specific plan will include a set of questions or conditions that must be addressed completely by the Investigator and a specified time period during which the Investigator must provide a written response.
If an emergency occurs, institutional officials, the IRB Chair, or an appropriately appointed designee may suspend a study until the next regularly scheduled meeting of the IRB. Alternatively, the Chair may convene an emergency meeting of the full committee to consider suspension of a study before the next regularly scheduled meeting. In the event that an emergency suspension is considered, the Chair must notify the PI and appropriate institutional officials (e.g., the Chancellor, the Vice Chancellor for Academic Affairs and Research Administration, the Director of the ORSP, direct supervisors of the PI, and the appropriate department of agency head). The full committee at the next scheduled meeting must review all emergency suspensions.

Termination

Termination is a non-voluntary process that results in permanent discontinuation of all study-related activities. The IRB may require a study that has been terminated to be entirely resubmitted and re-approved with a new protocol. Termination may occur for the following reasons:

- Unexpected and serious adverse effects that significantly increase risks relative to benefits
- Evidence that an Investigator failed to adequately protect participants in a research study
- Willful or repeated failure to comply with federal regulations, state laws, or institutional rules that govern human research activities
- Proven research fraud or scientific misconduct
- At the request of institutional officials who have been charged with responsibility for oversight of research involving human subjects (e.g., the Chancellor or the Vice Chancellor for Academic Affairs and Research Administration)
- At the request of the study sponsor, the Federal Drug Administration, Office for Human Research Protections, or other duly authorized regulatory or governmental department or agency head
- The Investigator leaves the institution and fails to request closure of the study or fails to reassign the Investigator’s responsibilities and duties to another qualified Investigator
- Failure to respond to repeated requests from the IRB regarding required actions on the part of the Investigator to maintain an active protocol
- Any other reason deemed necessary by a simple majority vote of the convened IRB (a quorum must be present)

A research study that is terminated by the IRB will be reported to the study sponsor, institutional officials, and to the appropriate department or agency head. Disciplinary action or sanctions may be appropriate. Decisions will be made on a case-by-case basis. At the IRB level, appropriate sanctions might include a request for further information, an audit of ongoing clinical research activities, or suspension of all ongoing research conducted by the same Investigator or group of Investigators until all research activities are shown to be free of similar problems. The Investigator will be reminded that if a study is terminated, no further enrollment or data collection is permitted.

If discontinuation of study-related therapy might result in increased risk of significant harm to an individual or a group of study subjects, the IRB reserves the right to permit continued therapy with
an investigational drug, device, or biologic for subjects who are already enrolled in a treatment study. Enrollment of new subjects will not be permitted.

Institutional officials have the right to terminate any research activity without review by or approval of the IRB. Institutional review is broader in scope and may result in termination for reasons, other than those listed above.

❖ **Appeals Procedures For IRB Actions**

Information pending.
CHAPTER 16

*IRB Records*

This section concerns IRB records.

IRB Records
**IRB Records**

The IRB office maintains the following records:

- A current list of IRB membership and qualifications.
- Agenda and minutes of meetings, including information regarding member attendance, discussions held, decisions made, and voting results.
- All materials submitted to the committee for initial and continued review of each study including: IRB applications, protocols, submitted and final consent forms, serious adverse event and death reports, proposed amendments, progress reports, correspondence generated between the committee and the Investigators, and, where applicable, correspondence from sponsoring agencies.

All records are retained electronically following the inactivation or closure of a project.
CHAPTER 17

Office of Research Compliance

This section offers information about the Office of Research Compliance.

ORC Information
The Office of Research Compliance (ORC) was established to help researchers and the entire University achieve and maintain compliance with federal regulations and institutional requirements governing research. The ORC’s primary purpose is to support activities that protect human subjects and to elevate the general level of research through systematic evaluation of research activities. The ORC coordinates the implementation and oversight of a comprehensive research compliance program for the University. As part of its role, the ORC conducts audits, educates staff on research and regulatory compliance, and reviews potential noncompliance.

The ORC is a department of the Academic Affairs Division and reports directly to the UAMS Vice Chancellor for Academic Affairs and Research Administration. It also functions as the auditing and compliance body for the UAMS Institutional Review Board.

Study audits conducted by the ORC include random or selected audits, directed or “for cause” audits, and specific document or process audits. The IRB may ask the ORC to conduct an audit based on an Investigator’s protocol activities (large numbers of active protocols, subject enrollment, reported protocol deviations and/or serious adverse events). The ORC also may initiate audits as quality assurance or safety assessments or as educational activities for researchers. Audit findings are reported to the UAMS IRB, Investigator and the UAMS Vice Chancellor for Academic Affairs and Research Administration.

The ORC, upon the request of research staff, will conduct a review of documents in preparation for an external agency audit such as the FDA or NIH.

Education is a very large focus for the ORC. Education of researchers and their staff is accomplished through quarterly coordinator training classes, monthly one-hour Question and Answer seminars, and through advisory consultation sessions. Interactive web-based training programs are available in the areas of Protection of Human Subjects (Biomedical and Behavioral) and HIPAA for Research.

Regulatory consultations for the preparation of Sponsor-Investigator Investigational New Drug (IND) exemptions and Monitoring of IND studies and informational packets on the preparation are available for Investigators who want to conduct research under their own IND.

The ORC will review and advise on protocols and protocol preparation when requested. This office will also advise Investigators preparing their own dosage forms on current Good Manufacturing Practices (cGMP).

To contact the Office of Research Compliance:

Telephone: 501-526-6876
Facsimile: 501-526-6272
Website: http://www.uams.edu/orc/
CHAPTER 18

References

This section offers references that can be used in research.

Ethical Principals And Codes

Federal Regulatory & Advisory Guidelines

Federal Regulatory Agencies

Local References

Accreditation References
Ethical Principles And Codes

- **Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research**
- Guidelines for Good Clinical Practice
- International Conference on Harmonization of Technical Requirements for Registration of Pharmaceuticals for Human Use (ICH)
- ICH Considerations for Clinical Trials
- National Bioethics Advisory Commission
- **Nuremberg Code**
- World Medical Association Declaration of Helsinki

Federal Regulatory & Advisory Guidelines

- Code of Federal Regulations
- Department of Veterans Affairs M3-Part I
- FDA Information and Regulations
- Investigational Devices 21 CFR 812 – U.S. FDA
- Investigational Drugs 21 CFR 312 and 314 – U.S. FDA
- NIH Policy and Guidelines on the Inclusion of Children as Participants in Research Involving Human Subjects
- Protection of Human Subjects 21 CFR 50 – U.S. FDA
- Protection of Human Subjects 21 CFR 50 – U.S. FDA
- Protection of Human Subjects 45 CFR 46 – U.S. FDA
- HIPAA Privacy and Research 45 CFR 164

Federal Regulatory Agencies

- National Institutes of Health
- Office of Biotechnology Activities
- Office for Research and Compliance
- Office of Human Research Protections
• U.S. Food and Drug Administration

Local References

UAMS Faculty Handbook
UAMS Federalwide Assurance
UAMS IRB Investigators Handbook for Human Studies
UAMS IRB Policies and Procedures

Accreditation References

CHAPTER 19

Glossary

This section contains glossary items.
Glossary Items

- **Accrual**
  The process of getting subjects into a trial or the number of subjects in a trial or planned to be in a trial. The number of subjects includes the sum of those screened and enrolled (regardless of whether they completed the study).

- **Adult Risk**
  The probability of harm or injury (physical, psychological, social, or economic) occurring as a result of participation in a research study. Both the probability and magnitude of possible harm may vary from minimal to significant. Federal regulations define only "minimal risk."

- **Adult Minimal Risk**
  A risk is minimal where the probability and magnitude of harm or discomfort anticipated in the proposed research are not greater, in and of themselves, than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests [38CFR16.102(i)].

- **Approved**
  The project and its study tools, including the informed consent documents, are approved as submitted. Once the investigator receives the IRB approval letter, the study may begin.

- **Approved with Major Revisions**
  A vote such as this incorporates all the noted contingencies. The project requires major revisions which must be addressed and re-reviewed by the convened IRB before the IRB can grant final approval.

- **Approved with Minor Revisions**
  A vote such as this incorporates all the noted contingencies. The project requires minor revisions which must be addressed before final approval can be granted. Minor revisions may be reviewed and approved through the expedited process.

- **Arm**
  Any of the treatment groups in a randomized trial.
• Assent

A child’s affirmative agreement to participate in research. Mere failure to object should not, absent affirmative agreement, be construed as assent. Assent is generally sought beginning at age 7. Assent is a process, not a form. However, Assent can be documented either on a separate assent form specifically tailored to children (especially adolescents) or on the same document used to obtain parental permission.

• Audit

A comparison of Raw Data and associated records with the interim or Final Study Report in order to determine whether the Raw Data have been accurately reported, to determine whether testing was carried out in accordance with the protocol and Standard Operating procedures (SOP), to obtain additional information not provided in the Final Study Report, and to establish whether practices were employed in the development of data that would impair their validity.

• Benefit

A valued or desired outcome; an advantage.

• Blind

Used with respect to a randomized trial, a randomized trial is blind if the subject is not told which arm of the trial he or she is on.

• Certificate of Confidentiality

Where data are being collected from subjects about sensitive issues (such as illegal behavior, alcohol or drug use, or sexual practices), researches can obtain an advance grant of confidentiality from the Public Health Service that will provide protection against involuntary disclosure of the research subject’s identity and the subject’s participation in the study, even against a subpoena for research data.

• Children

Persons who have not attained the legal age for consent to treatment procedures involved in the research, as determined under the applicable law of the jurisdiction in which the research will be conducted [45 CFR 46.402 (a)].

• Clinical Investigation

Any experiment that involves a test article and one or more human subjects and that is subject to the Food and Drug Administration (FDA) regulations. This includes all research using a test article in a human subject as well as experiments that support applications for research or marketing permits for products.
• Clinical Trials
Any form of planned experiment, which involves subjects and is designed to elucidate the most appropriate treatment of future subjects with a given medical condition. The essential characteristic of a clinical trial is that the results based on a limited sample of subjects are used to make inferences about how treatment should be conducted in the general population of subjects who will require treatment in the future.

• Cognitively Impaired Individuals
Those persons having a psychiatric or developmental disorder that affects cognitive or emotional functions to the extent that the capacity for judgment and reason is significantly diminished.

• Compassionate Use
Use of an investigational drug for treatment of an individual subject for a single use or a single course of treatment that is not covered by an existing IRB approved protocol.

• Compliance
Action in accordance with a request or institution.

• Consumer Preference Testing
Studies in which preferences are measured for approved devices or modifications of approved devices. Such testing does NOT involve the collecting of safety or efficacy data.

• Continuing Non-compliance
A pattern of repeated actions or omissions taken by an Investigator (or study personnel) that indicates a deficiency in the ability or willingness to comply with Federal Regulations, UAMS and/or other institutional policies and procedures, or the determinations of the UAMS IRB.

• Current Good Manufacturing Practices (cGMP)
The minimum requirements for methods to be used in, and the facilities or controls to be used for, the manufacture, processing, packing, or holding of a drug or biologic to assure that such drug meets the requirements of the Food, Drug, and Cosmetic Act as to safety, and has the identity and strength and meets the quality and purity characteristics that it purports or is represented to possess.

• Current Good Tissue Practices (cGTP)
The minimum requirements for methods to be used in, and the facilities or controls to be used for, the manufacture of human cell, tissue, and cellular and tissue-based products (HCT/P); recordkeeping; and the establishment of a quality program. (Effective May 25, 2005)
• Data and Safety Monitor (DSM)
An individual assigned to conduct interim monitoring of accumulating data from research activities to assure the continuing safety of research participants, relevance of the study question, appropriateness of the study, and integrity of the accumulating data. The individual should have relevant medical, ethical and scientific, and monitoring expertise.

• Data and Safety Monitoring Board (DSMB)
A formally appointed independent group consisting of at least three (3) members assigned to conduct interim monitoring of accumulating data from research activities to assure the continuing safety of research participants, relevance of the study question, appropriateness of the study, and integrity of the accumulating data. Membership should include expertise in the relevant field of study, statistics, and research study design. DSMBs are often referred to as Data and Safety Monitoring Committees (DSMC).

• Data Safety Monitoring Plan (DSMP)
A DSMP describes how the Investigator plans to oversee the research participant’s safety and welfare and how adverse events will be characterized and reported. The intensity and frequency of monitoring should be tailored to fit the expected risk level, complexity, phase and size of the particular study.

• Dead Fetus
A fetus ex utero, which exhibits none of the following: heartbeat, spontaneous respiratory activity, spontaneous movement of voluntary muscles, nor pulsation of the umbilical cord (if still attached).

• Declined
The project has serious deficiencies affecting the safety and welfare of the projected subject population. Protocols that are declined may not be resubmitted to the IRB under the same ARIA Record. The protocol requires major revision of safety issues and an entirely new protocol submission. The PI will be provided with comments explaining rationale for Declined decision.

• Double Blind
Used with respect to a randomized trial, a randomized trial is Double Blind if neither the subject or the subject’s Investigator or physician are told which Arm of the study he or she is on. The purpose is to prevent any bias in treatment or reporting of results from being introduced.
• Economically Disadvantaged Individuals
Those persons who struggle to provide basic necessities for themselves and their families or communities. The use of financial incentives for research participation is a special issue with economically disadvantaged persons.

• Educationally Disadvantaged Individuals
Those persons who may have educational deficits, learning disabilities, or cultural backgrounds that limit communication with a researcher.

• Elderly Subjects
Persons over the age of 65 years of age.

• Emancipated Minor
A legal status conferred upon persons who have not yet attained the age of legal competency as defined by state law, but who are entitled to treatment as if they had by a virtue of assuming adult responsibilities.

• Emergency Use
Use of a test article on a human subject in a life-threatening situation in which no standard acceptable treatment is available and in which is not sufficient time to obtain IRB approval (21 CFR 50.27).

• Experimental Group
The Arm of a randomized trial that gets the new or “experimental” treatment. In some randomized trials, both of the treatments are standard treatments.

• Expired Studies
Studies that expire due to lack of continuing review. For more information, see IRB Policy 7.6 (Continuing Review).

• FDA Acknowledgment Letter
This letter typically comes 1-2 weeks after the FDA receipt of an IND submission. This letter assigns the IND number, gives the date of receipt, and reminds the sponsor-investigator of their obligations under the IND. This is NOT an approval to begin clinical trials. Clinical trials may not begin until 30 days after the IND receipt date or later if the IND is placed on clinical hold. The Sponsor-Investigator may or may not receive a letter permitting them to proceed with their trial. If a clinical hold is placed on the IND, the FDA should issue a letter detailing the IND deficiencies.
• Federal Oversight Body

Agencies to whom UAMS must report non-compliance according to the terms of the IRB Federalwide Assurance. These include the Office of Human Subjects Protection, the Food and Drug Administration, and the Office of Research Integrity.

• Federalwide Assurance (FWA)

Document, which formalizes an institution’s commitment to protect human, subjects and is required by any institution that participates in Federally supported human subject research.

• Fetus

The product of conception from the time of implantation (as evidenced by any of the presumptive signs of pregnancy, such as missed menses, or a medically acceptable pregnancy test), until a determination is made, following expulsion or extraction of the fetus, that it is viable.

• Food and Drug Administration (FDA)

The U.S. Food and Drug Administration is a scientific, regulatory, and public health agency that oversees human and animal drugs, therapeutic agents of biological origin, medical devices, radiation-emitting products for consumer, medical, and occupational use, cosmetics, and animal feed. FDA scientists evaluate applications for new human drugs and biologics, complex medical devices, food and color additives, infant formulas, and animal drugs. It also monitors the manufacture, import, transport, storage, and sale of the aforementioned products as well as inspects facilities for compliance with regulations.

• Funding Source

An individual, pharmaceutical company, device manufacturer, government agency, academic institution, private or other organization that provides complete or partial financial, in kind, or other support for a research study.

• Good Clinical Practices (GCP)

International ethical and scientific quality standards for designing, conducting, monitoring, recording, auditing, analyzing, and reporting studies. Insures that the data reported is credible and accurate and that subject’s rights and confidentiality are protected.

• Guardian

An individual who is authorized under applicable state or local law to give permission on behalf of a child to general medical care [45 CFR 46.402 (3)]. May also apply to an individual who can provide consent for an incapacitated subject, cf., Surrogate.
• Human Subject (subject and participant used interchangeably)

1) An individual who is or becomes a participant in research either as a recipient of a test article or as a control;

2) A living individual about whom an investigator (whether professional or student) conducting research obtains:
   a. Data, of any kind, through intervention or interaction with the individual; OR
   b. Identifiable private information even in the absence of intervention or interaction.

• Human Subject Research

Any research that involves human subjects including any clinical investigation.

• Imminent Threat of an AE in Research

Any situation in which an adverse event in research has not yet occurred but is likely to occur, as determined by an IRB, research, or clinical team member, without preventative measures. Examples include potential harm to subjects due to stolen records and possible release of confidential data, or an error in research billing that puts the subject at potential financial harm.

• IND Monitoring Plan

Existing requirements for sponsors of clinical investigations involving new drugs for human and animal use (including biological products for human use) and medical devices under 21 CFR Parts 312 and 511, and 812 and 813, respectively, require that a sponsor or sponsor/investigator monitor the progress of a clinical investigation. The monitoring functions may be delegated to a contract research organization as defined under 21 CFR 312.3. Proper monitoring assures adequate protection of the rights of human and safety of all participants involved in clinical investigations and the quality and integrity of the resulting data submitted to the Food and Drug Administration (FDA). For more information, see IRB Policy 7.8 (IRB Oversight of Activities for Data Safety Monitoring).

• Informed Consent

The process of ongoing explanations to help a subject make educated decisions about whether to begin or continue participating in a research protocol or procedure.

• Informed Consent Document

A written summary of the research protocol (including its purpose, treatment procedures and schedule, potential risks and benefits, alternative to participation, etc.) and explanation of the rights of a research subject. Designed to begin the informed consent process.
• Inspection
Officially conducted audit by relevant authorities at the site of investigation and/or at the sponsor site to verify adherence to regulations.

• IRB Authorization Agreement
Formal, written agreement documenting the roles and responsibilities of Institution providing the IRB and Institution relying on the IRB.

• IRB of Record
IRB listed as an approved reviewing body for Institution’s research.

• Institutional Review Board
Any board, committee, or other group formally designated by an institution to review, to approve the initiation of, and to conduct periodic review of, biomedical research involving human subjects. The primary purpose of such review is to assure the protection of the rights and welfare of the human subjects [21 CFR 56.102(g)].

• Interaction
Includes communication or interpersonal contact between investigator and subject or participant.

• Intervention
Includes both physical procedures by which data are gathered (for example, venipuncture) and manipulations of the subject’s environment that are performed for research purposes.

• Investigational Agents
A pharmaceutical form of an active ingredient or placebo being tested or used as a reference in a clinical trial. This includes products with marketing authorization when they are formulated, packaged, or administered in a way different from the approved form, products used for off-label use, or products used to gain further information about an approved use (such as an unapproved population).

• Investigational Device
Any healthcare product that does not achieve its primary intended purposes by chemical action or by being metabolized. A medical device that is the subject of a clinical study designed to evaluate the effectiveness and/or safety of the device. Investigational use also includes clinical evaluation of certain modifications or new intended uses of legally marketed devices.
• **Investigational Drugs/Investigational Biologics**

A new drug or biological drug that is used in a clinical investigation. It also includes a biological product that is used in vitro for diagnostic purposes. Investigational drugs or biologics may include products that are not generally recognized as being safe and effective by the FDA or products already approved by the FDA as safe and effective for specific indications but are being studied for new indications, doses, strengths, dosing frequency, or in new populations. This latter description is known as off-label use.

• **Investigational Device Exemption (IDE)**

An FDA approved investigational device exemption (IDE) permits a device that otherwise would be required to comply with a performance standard or to have pre-market approval to be shipped lawfully for the purpose of conducting investigations of that device.

• **Investigational New Drug (IND)**

Current Federal law requires that a drug be the subject of an approved New Drug Application (NDA) before it is transported or distributed across state lines. Because a sponsor will probably want to ship the investigational drug to clinical investigators in other states, a sponsor must seek an exemption from that legal requirement. The IND is the means through which the sponsor technically obtains this exemption from the FDA.

• **Investigator (Principal Investigator)**

An individual who conducts an investigation, i.e., under whose immediate direction research is conducted, or, in the event of an investigation conducted by a team of individuals, is the responsible leader of that team.

• **In vitro fertilization**

Any fertilization of human ova which occurs outside the body of a female, either through admixture of donor human sperm and ova or by any other means.

• **Legally Authorized Representative (LAR)**

An individual or judicial or other body authorized under applicable law to consent on behalf of a prospective subject to the subject’s participation in the procedures involved in the research.

• **Life-Threatening**

Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted and diseases or conditions with potentially fatal outcomes, where the end point of clinical trial analysis is survival.
• Mature Minor
Someone who has not reached adulthood (as defined by state law) but who may be treated as an adult for certain purposes (e.g., consenting to medical care). Note that a mature minor is not necessarily an emancipated minor.

• Minimal Risk
A risk is minimal where the probability and magnitude of harm or discomfort anticipated in the proposed research are not greater, in and of themselves, than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests. For example, the risk of drawing a small amount of blood from a healthy individual for research purposes is no greater than the risk of doing so as part of routine physical examination.

• Multi-center
Refers to a study that is being done at several hospitals or institutions simultaneously.

• Non-compliance
Failure to comply with applicable Federal Regulations, UAMS IRB policies and procedures, UAMS and/or other institutional policies and procedures, or the determinations of the UAMS IRB.

• Non-Human Subject Research
An activity determined by the IRB to not meet the definitions of Human Subject Research as per this policy.

• Non-Significant Risk (NSR) Device
A device that does not meet the definition of a significant risk device.

• Non-Significant Risk (NSR) Device Study
A study of a device that does not meet the definition for a significant risk device and does not present a potential for serious risk to the health, safety, or welfare of participants. NSR device studies should not be confused with the concept of "minimal risk”.

• Nonviable Fetus
A fetus ex utero, which, although living, is not viable.
• Pediatric Risk Category I
Minimal Risk.

• Pediatric Risk Category II
Greater than minimal risk, but presenting the prospect of direct benefit to individual participants.

• Pediatric Risk Category III
Greater than minimal risk and no prospect of direct benefit to individual participants but likely to yield important generalizable knowledge about the participant’s disorder or condition.

• Pediatric Risk Category IV
Otherwise not approvable, but presents an opportunity to understand serious health or welfare problems of children.

• Permission
The agreement of parent(s) or guardian to the participation of their child or ward in research [45 CFR 46.402 (c)].

• Placebo
An inert substance, such as a sugar pill.

• Pregnancy
Encompasses the period of time from confirmation of implantation (through any of the presumptive signs of pregnancy, such as missed menses, or by a medically acceptable pregnancy test), until expulsion or extraction of the fetus.

• Prisoner
Any person who is sentenced to a penal institution under a criminal or civil statute as well as individuals detained in other facilities by virtue of statutes or commitment procedures, which provide alternatives to criminal prosecution or incarceration in a penal institution [45 CFR 46.303(c)].
• Private Information

Information about behavior that occurs in a context in which an individual can reasonable expect that no observation or recording is taking place; and Information which has been provided for specific purposes by an individual and which the individual can reasonably expect will not be made public (for example, Medical records). Private Information must be individually identifiable (identity of subject is or may readily be ascertained or associated with the information) in order to constitute research involving human subjects.

• Protocol

A document, which states the rationale, objectives and statistical design and methodology of the trial, with the conditions under which it, is to be performed and managed.

• Protocol Deviation

An unplanned or unforeseen change in an ongoing study that is not covered under an approved IRB protocol.

• Protocol Violation

An unplanned or unforeseen change in an ongoing study that is not covered under an approved IRB protocol. Usually represents a more serious non-compliance problem than a protocol deviation and is noted after the fact or based on a technical error resulting in the protocol or standard operating procedure not being followed.

• Randomized Trial

A clinical trial with at least two arms, in which the decision as to which arm a new subject is assigned, is made by change, for instance, by the flip of a coin or by using a computer to select randomly.

• Related Event

An event is “related” if it is likely to have been caused by the research activity

• Research

A systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge.

• Risk
The probability of harm or injury (physical, psychological, social, or economic) occurring as a result of participation in a research study. Both the probability and magnitude of possible harm may vary from minimal to significant. Federal regulations define only "minimal risk."

- **Scientific Misconduct**
  Fabrication, falsification, or plagiarism in proposing, performing or reviewing research, or in reporting research results.

- **Serious Adverse Event**
  Any adverse event that results in any of the following outcomes; death, a life-threatening adverse event, inpatient hospitalization or prolongation of existing hospitalization, a persistent or significant disability/incapacity, or a congenital anomaly/birth defect. Important medical events that may not result in death, be life-threatening, or require hospitalization may be considered a serious adverse event. When, based upon appropriate medical judgment, they may jeopardize the subject any may require medical or surgical intervention to prevent one of the outcomes listed in this definition. Examples of such medical events include allergic bronchospasm requiring intensive treatment in an emergency room or at home, blood dyscrasias or convulsions that do not result in inpatient hospitalization, or the development of drug dependency or drug abuse. Additional examples may include suicidal ideation or attempts, and unintentional revealing of some genetic information to insurers.

- **Serious Event**
  An event is “serious” if it involves considerable detriment to one or more persons (who may or may not be subjects), or required intervention to prevent one or more persons from experiencing considerable detriment or harm.

- **Serious Non-compliance**
  An action or omission taken by an Investigator (or study personnel) that any other reasonable Investigator would have foreseen as compromising the rights and/or welfare of a subject.

- **Significant Risk (SR) Device**
  A device that presents a potential for serious risk to the health, safety, or welfare of a subject and (1) is an impact; or (2) is used in supporting or sustaining human life; or (3) is of substantial importance in diagnosing, curing, mitigating or treating disease, or otherwise prevents impairment of human health; or (4) otherwise presents a potential for serious risk to the health, safety, or welfare of a subject (21 CFR Part 812).

- **Significant Risk (SR) Device Study**
A study of a device that presents a potential for serious risk to the health, safety, or welfare of a participant and 1) is intended as an implant; 2) is used in supporting or sustaining human life; or otherwise prevents impairment of human health; 3) is of substantial importance in diagnosing, curing, mitigating or treating disease, or otherwise prevents impairment of human health; or 4) otherwise presents a potential for serious risk to the health, safety, or welfare of a participant.

- **Sponsor**

Any person or entity that takes responsibility for and initiates a research study. The sponsor may be an individual, pharmaceutical company, device manufacturer, governmental agency, academic institution, private organization, or other organization.

- **Sponsor/Investigator**

An individual who both initiates and conducts an investigation, and under whose immediate direction the investigational drug is administered or dispensed. The term does not include any person other than an individual. The FDA requirements applicable to a sponsor-investigator under this part include both those applicable to an investigator and a sponsor.

- **Standard**

A broad description of performance expectation.

- **Standard Operating Procedures (SOPs)**

Detailed, written procedures for the uniform performance of a function. These are the standard procedures that trained study personnel must follow to ensure the quality and integrity of the work performed during a study.

- **Substantive Action by the IRB**

An action taken by the IRB that materially alters the substance and meaning of a protocol, informed consent form or process, or investigator status, including, but not limited to, restriction, suspension or termination of a study or investigator participation, and actions taken to prevent future occurrence(s) of the AE in research.

- **Surrogate**

A person that can provide legal consent for an incapacitated subject, cf. Guardian.

- **Suspended for Cause**

An action initiated by the IRB to temporarily stop some or all research procedures until the outlined requirements are met.
• Tabled
Serious deficiencies in submitted protocol, continuing review or modification with issues to be addressed by the investigator and reviewed by the full IRB before the IRB can grant approval. The PI will be provided with contingencies to explain rationale for Tabled decision. PIs should be aware that the IRB upon receiving the responses to a tabled protocol may have additional requested revisions.

• Terminated for Cause
An action initiated by the IRB to permanently stop some or all research procedures

• Test Article
Any drug (including a biological product for human use), medical device for human use, human food additive, color additive, electronic product or any other article subject to FDA regulations.

• Treatment IDE
A mechanism through the FDA for providing eligible participants with investigational devices for the treatment of a serious or life-threatening illness for which there are no satisfactory alternatives.

• Unanticipated Adverse Device Effect
Any serious adverse effect on health or safety or any life-threatening problem or death caused by, or associated with, a device, if that effect, problem, or death was not previously identified in nature, severity, or degree of incidence in the investigational plan or application (including a supplementary plan or application), or any other unanticipated serious problem to participants or others associated with a device that relates to the rights, safety, or welfare of participants.

• Unanticipated Event
An event is “unexpected” when its specificity, nature, severity or incidence are not accurately reflected in the information previously reviewed and approved by the IRB.

• Unanticipated Problem Involving Risks to Participants or Others
Any event that was serious, unanticipated and related to the research
• Unexpected Adverse Event
Any adverse event not specified in or not consistent with the risk information in the protocol, investigator’s brochure or device manual. Unexpected, as used in this definition, refers to an adverse event that has not been previously observed.

• Unexpected Event
Any adverse event not specified in or not consistent with the risk information in the protocol, investigator’s brochure or device manual. Unexpected, as used in this definition, refers to an adverse event that has not been previously observed.

• Viable
As it pertains to the fetus means being able, after either spontaneous or induced delivery, to survive (given the benefit of available medical therapy) to the point of independently maintaining heartbeat and respiration. If a fetus is viable after delivery, it is a premature infant.

• Vulnerable Subjects
Individuals whose willingness to volunteer in a research study may be unduly influenced or coerced; and individuals with limited autonomy. These individuals may include, but are not limited to, children, prisoners, pregnant women, mentally disabled, or economically or educationally disadvantaged persons.

• Waiver
A request to FDA to waive applicable requirements under 21 CFR 312 – Investigational New Drug Application.
CHAPTER 20

Abbreviations

This section contains abbreviations.

Abbreviations
## Abbreviations

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<td>OHRP</td>
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<td>Office of Research and Sponsored Programs</td>
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<td>Principal Investigator</td>
<td>PI</td>
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<td>Protocol Review and Monitoring Committee</td>
<td>PRMC</td>
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<td>University of Arkansas for Medical Sciences</td>
<td>UAMS</td>
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<td>UAMS Biosafety Committee</td>
<td>UBC</td>
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<td>VA Research and Development</td>
<td>VA R/D</td>
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CHAPTER 21

❖ **Resource List of Committees and Institutional Contacts**

This section contains the contact information for Arkansas Children’s Hospital (ACH), Arkansas Children’s Hospital Research Institute (ACHRI), Central Arkansas Veterans Healthcare System (CAVHS), and University of Arkansas for Medical Sciences (UAMS).

Arkansas Children’s Hospital
Arkansas Children’s Hospital Research Institute
Central Arkansas Veterans Healthcare System
University of Arkansas for Medical Sciences
### ARKANSAS CHILDREN’S HOSPITAL (ACH) website

<table>
<thead>
<tr>
<th>Service</th>
<th>Phone Number</th>
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<tbody>
<tr>
<td>Main Number</td>
<td>(501) 364-1100 (Phone)</td>
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<tr>
<td>Research Pharmacy</td>
<td>(501) 364-2596 (Phone)</td>
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<tr>
<td></td>
<td>(501) 364-2595 (Fax)</td>
</tr>
<tr>
<td>Pediatric Clinical Research Unit</td>
<td>(501) 364-2338 (Phone)</td>
</tr>
<tr>
<td>Radiation Safety Committee</td>
<td>(501) 364-3800 (Phone)</td>
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### ARKANSAS CHILDREN’S HOSPITAL RESEARCH INSTITUTE (ACHRI) website

<table>
<thead>
<tr>
<th>Service</th>
<th>Phone Number</th>
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<tr>
<td>Assistance with IRB Submissions, ARIA, and HIPAA</td>
<td>(501) 364-3571 (Phone)</td>
</tr>
<tr>
<td>Clinical Trials (Pharmaceutical/Industry), Confidentiality and Study Agreements</td>
<td>(501) 364-2705 (Fax)</td>
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<tr>
<td>CUMG Awards</td>
<td>(501) 364-3581 (Phone)</td>
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<tr>
<td>Federal and Private Grants</td>
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<tr>
<td>Pediatric Clinical Research Unit Coordinator</td>
<td>(501) 364-2760 (Phone)</td>
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<tr>
<td>Procedure Prices for Research</td>
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<td>Research Coordinator Pool</td>
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<tr>
<td>Subject Tracking System</td>
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<tr>
<td>Manuscript Grant Writing/Editing</td>
<td>(501) 364-2469 (Phone)</td>
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<tr>
<td>Grants Accounting</td>
<td>(501) 364-2513 (Phone)</td>
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<tr>
<td>Research Compliance Specialist/Education Coordinator</td>
<td>(501) 364-2862 (Phone)</td>
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<tr>
<td>Research Computer Systems</td>
<td>(501) 364-6546 (Phone)</td>
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**CENTRAL ARKANSAS VETERANS HEALTHCARE SYSTEM (CAVHS) website**

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<tr>
<td>Main Number</td>
<td>(501) 257-1000 (Phone)</td>
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<tr>
<td>Biomedical Research Foundation</td>
<td>(501) 257-4517 (Phone)</td>
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<tr>
<td></td>
<td>(501) 257-4623 (Fax)</td>
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<tr>
<td>Subcommittee for Research Safety</td>
<td>(501) 257-4816 (Phone)</td>
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<td>(501) 257-4821 (Fax)</td>
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<td>Radiation Safety Committee</td>
<td>(501) 257-6108 (Phone)</td>
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<tr>
<td>Research Compliance Office</td>
<td>(501) 257-5558 (Phone)</td>
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<td>Research &amp; Development Committee</td>
<td>(501) 257-4816 (Phone)</td>
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<td>(501) 257-4821 (Fax)</td>
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<tr>
<td>Research Pharmacy</td>
<td>(501) 257-6338 (Phone)</td>
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**VA Research website**
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<th><strong>University of Arkansas for Medical Sciences (UAMS) website</strong></th>
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<td><strong>Animal Research Committee</strong></td>
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<td><strong>Biosafety Committee, Dr. Lee Soderberg</strong></td>
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<td><strong>Biohazards Committee</strong></td>
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<td><strong>DNA Committee</strong></td>
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<tr>
<td><strong>Dr. Charles Winter, Associate Dean of Research</strong></td>
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<td><strong>College of Medicine</strong></td>
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<td><strong>General Clinical Research Center (GCRC)</strong></td>
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<tr>
<td><strong>Steven C. Elbein, MD</strong></td>
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<tr>
<td><strong>Professor of Medicine, Program Director</strong></td>
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<tr>
<td><strong>Suzanne Ritter Lumpkin, MS, JD</strong></td>
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<tr>
<td><strong>GCRC Administrator</strong></td>
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<td><strong>Institutional Review Board (IRB)</strong></td>
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<td><strong>Including ARIA Usernames/Passwords</strong></td>
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<tr>
<td><strong>Jennifer Sharp</strong></td>
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<td><strong>Associate Director, ORSP</strong></td>
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<td><strong>Office for Clinical Trials</strong></td>
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<tr>
<td><strong>Dr. Thomas G. Wells, Director</strong></td>
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<tr>
<td><strong>Julia Washam, R.N.</strong></td>
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<td><strong>Liaison Specialist</strong></td>
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<td><strong>Office of Research and Sponsored Programs</strong></td>
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<td><strong>Tim Atkinson, Director</strong></td>
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<td><strong>Research Privacy Officer</strong></td>
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<td><strong>Office of Research Compliance</strong></td>
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<td><strong>Danna K. Carver, Director</strong></td>
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<td><strong>Kevin Simmons, UAMS Compliance Educator</strong></td>
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<td><strong>Pharmacy Committee</strong></td>
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<td><strong>Mike Parr, Pharm.D.</strong></td>
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<td><strong>Protocol Review &amp; Monitoring Committee (PRMC)</strong></td>
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<td><strong>Angie Smith, LCSW, CRA</strong></td>
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<td><strong>PRMC Administrator</strong></td>
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Office of Research Compliance Homepage

The primary purpose of the Office of Research Compliance is to support those activities that protect human research subjects and elevates the general level of research through systematic evaluation of research activities.

The main functions of the ORC include Auditing, Education and Advisory Consultation efforts that promote research compliance and integrity.

The ORC functions as the auditing and compliance body for the UAMS Institutional Review Board. Our office is a component of the campus Human Research Protections Program (HRPP). ORC reports directly to the senior campus research official, the Vice Chancellor for Academic Affairs and Research Administration.

To find out more about the Office of Research Compliance click on the About ORC button to the left.

Announcements

October 2005 Coordinator's Training - at the VA. Click here to register

Investigator's Handbook. Click here to download.

New Links

OHRP - Assurance page
OHRP - Registration of an Institutional Review Board (IRB) or Independent Ethics Committee (IEC)
OHRP - Policy Guidance by topics
Research use of radioactive agents and when an IND is NOT needed.
Protocol Writing Guideline (Word Document)

Click here for the MANDATORY EDUCATION POLICY FOR INVESTIGATORS/STUDY PERSONNEL PARTICIPATING IN HUMAN SUBJECT RESEARCH PROJECTS

HIPAA for Research TRAINING

Click on the text above for the course you want.

http://www.uams.edu/orc/
**UAMS Patent and Copyright Committee**

The UAMS Patent and Copyright Committee functions to implement the University of Arkansas Patent and Copyright Policy (Board Policy 210.1) at UAMS. The Committee provides a review process for disclosures of patent, copyright, and other intellectual property developed by members of the UAMS community. The Committee evaluates the patentability and desirability of obtaining patent or other protection for the submitted disclosures as well as any patent obligations to research sponsors outside of the University. Recommendations by the Committee are submitted to the Chancellor.

"**What are patents, trademarks, service marks and copyrights?**"

**Patents and Patent Rights**

**Is my discovery patentable?**

**Is it**

- a process,
- machine,
- article of manufacture,
- composition of matter or
- an improvement of any of the above?


**Is it**

- Novel
- AND
- Non-obvious?


**Can You**

Adequately describe or enable the invention (for one of ordinary skill in the art to make and use)

**AND**

Detail claims to the invention in clear and definite terms

**THEN**

You should complete an invention disclosure form

If you are unsure of any of these, please complete an invention disclosure form to provide as much of the information as possible or contact a member of the UAMS Patent and Copyright Committee to discuss your ideas.