YAKIMA VALLEY MEMORIAL HOSPITAL
INSTITUTIONAL REVIEW BOARD
CONFIDENTIAL
AMENDMENT FORM

NOTIFICATION OF PROPOSED CHANGE IN PROTOCOL AND/OR CONSENT FORM

	PLEASE COMPLETE <u>EACH</u> SPACE IN THIS COLUMN (ATTACH SEPARATE SHEET, IF NECESSARY)
1. Title or Name of Protocol	
2. Principal Investigator.	
3. Co-Investigator(s).	
4. Study Sponsor.	
5. Date of Initial IRB Approval.	
6. Date of Study Start.	
7. **Present** Number of Subjects In Study.	Nationally: This facility:
8. **Proposed** Number of Subjects In Study.	Nationally: This facility:
9. Proposed Change(s).	**X** MINOR MAJOR
10. Do the Proposed Changes involve increased risks to Subjects?	YES X NO If **Yes**, please describe:
STUDY COORDINATOR NAME, PHONE, & E-MAIL ADDRESS	
PRINCIPAL INVESTIGATOR NAME	
PRINCIPAL INVESTIGATOR SIGNATURE	
DATE SIGNED	

REQUIRED ATTACHMENTS (original of the following):

1. **This Form**
2. **Pre-Change document(s)**
3. **Proposed Document(s)** (with additions **bolded** and deletions marked using ~~strikethrough~~)