

**YAKIMA VALLEY MEMORIAL HOSPITAL
INSTITUTIONAL REVIEW BOARD
CONFIDENTIAL**

FINAL STUDY REPORT

(IRB Review/Oversight No longer required)

PLEASE COMPLETE EACH 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.	NONE
5. Date of Initial IRB Approval.	
6. Total Number of Patients Entered into Study.	Nationally: _____ This facility: _____
7. Reason for Final Report.	<p style="text-align: center;">Single Emergency Use Only Study Closed--Long term Follow-Up Completed</p> <p style="text-align: center;">Other: Please describe: _____</p>
8. Please summarize Study Outcome or attach narrative.	
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. Any Pertinent Reports