

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

NOTICE OF STUDY ACCRUAL CLOSURE

(Notification of Accrual Closure Only—IRB review/oversight still 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. Date of Accrual closure.	
7. Total Number of Patients Entered into Study.	Nationally: _____ This Facility: _____
8. Please state if/how many patients will be followed on long-term follow-up. (IRB review required until long-term follow-up is complete.)	
9. Please summarize Study Outcome or attach narrative.	
STUDY COORDINATOR NAME & PHONE	
PRINCIPAL INVESTIGATOR NAME	
PRINCIPAL INVESTIGATOR SIGNATURE	
DATE SIGNED	

REQUIRED ATTACHMENTS (original of the following):

1. This Form
2. Any Pertinent Reports