



ST. PAUL'S HOSPITAL OF ILOILO, INC.

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SITE VISIT REPORT FORM (4.9)

IRB Protocol No.

Approval Date:

Protocol Title:

Study Site:

Address:

Principal Investigator:

Contact no. / Email:

Sponsor:

Sponsor
Contact Person:

Site Visit Date:

Duration of Visit:

No. of expected subjects:

Starting from:

Total subjects enrolled:

Finish:

1. Are site facilities appropriate? <input type="checkbox"/> Yes <input type="checkbox"/> No	Comment:
2. Are Informed Consents Recent and approved by the IRB? <input type="checkbox"/> Yes <input type="checkbox"/> No	Comment:
3. Any protocol non-compliance or violation? <input type="checkbox"/> Yes <input type="checkbox"/> No	Comment:
4. Any Adverse Events Found? <input type="checkbox"/> Yes <input type="checkbox"/> No	Comment:
5. Are Storage of data and investigating products are secured adequately? <input type="checkbox"/> Yes <input type="checkbox"/> No	Comment:
6. How well are study subjects protected? <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Not Good	Comment:
7. Any Outstanding tasks or result of the visit? <input type="checkbox"/> Yes <input type="checkbox"/> No	Comment:
8. Are there further actions or queries resulting from this site visit? <input type="checkbox"/> Yes <input type="checkbox"/> No	Comment:
9. Overall, does the study site provide adequate protection for the rights, safety or welfare of study subjects? <input type="checkbox"/> Yes <input type="checkbox"/> No	Comment:
10. Additional Remarks	

COMPLETED BY IRB SITE VISIT TEAM MEMBER:

Name:

Date:

Signature:

RECOMMENDED ACTION: (For IRB use only)

- UPHOLD ORIGINAL APPROVAL WITH NO FURTHER ACTION
- REQUEST FURTHER INFORMATION FROM THE PRINCIPAL INVESTIGATOR (specify)
- RECOMMEND FURTHER ACTION: (specify)