



# ST. PAUL'S HOSPITAL OF ILOILO, INC.

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## NOTIFICATION OF IRB DECISION FORM (Form 6.3)

Date:

Name of PI:  
(Principal Investigator)

Contact No.

This is to inform you of the IRB decision related to your application for review of the following documents:

Protocol Title:

Type of Review:

Full Board       Expedited Meeting  
Date:

Type of Submission:

Initial review       Amendment  
 Resubmission       Others

IRB Protocol No.:

Sponsor and Sponsor Protocol No.:

Protocol Version No.

Version Date

ICF Version No.

Version Date

Other Documents

IRB Decision  Disapproved  
 Minor revisions required       Major revisions required

Details of Action  
Required from  
the PI

[Empty box for details of action required from the PI]

\_\_\_\_\_  
Chairman  
Institutional Review Board

**Submitted By:**

**Received By:**

_____ Signature Over Name	_____ Signature Over Name
_____ Date:	_____ Date: