

INSTITUTIONAL REVIEW BOARD (IRB)

New York Presbyterian Hospital-Weill Medical College of Cornell University (WMC) and Affiliated Hospitals

ADVERSE EVENT & IND SAFETY REPORTING CUMULATIVE TABLE

PLEASE SUBMIT A COPY OF THE IRB APPROVED INFORMED CONSENT FORM WITH THIS FORM

WMC Protocol #: _____

WMC Protocol Title: _____

WMC Principal Investigator Name: _____ Fax Number _____

Date of Event	Case Number	Adverse Event	Relationship*	Location AE happened

* *Probably, Possibly, or Not Related to the study drug*

Do any of the above events require a change to be made to the consent form?

- NO** If **YES**, please submit a highlighted copy of the consent form with the changes & a non-highlighted copy for IRB stamping

_____ I would like an IRB confirmation of receipt of this AE/IND Safety Report
 Principal Investigator's Signature Date (Copy Sent: _____)

(Office Use Only)
IRB Adverse Event Sub-Committee

Signature: _____ Noted Questions { Answered _____ }

Date: _____ Full Board Review