**IRB Protocol Review Fee Invoice**

IRB Use Only

Protocol #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(please print)

Study Title: ****

Name of Funding Source (if any): 

**PRINCIPAL INVESTIGATOR**

Name: 

Department:  Phone: 

Email: 

|  |
| --- |
| **Application Fee Schedule***(Check appropriate Fee)* |
| **IRB Review Type** | **Industry Sponsored Research** | **Investigators with Other funding** | **Non- Sponsored research****(without grant or contract funding)** |
| **Initial Review** |  [ ]  $ 1000 |  [ ]  $ 250 |  [ ]  $ 100 |
| **Annual Review** |  [ ]  $ 500 |  [ ]  $ 125 |  [ ]  $ 100 |
| **Modification/Amendments** |  [ ]  $ 500 |  [ ]  $ 125 |  [ ]  $ 100 |
| **Humanitarian Use Device Reviews** |  [ ]  No Charge |

Attach check or money order for the appropriate amount.

 Payable to: N**avicent Health Institutional Review Board**

Send to:

**Navicent Health Institutional Review Board**

**777 Hemlock Street, MSC 113**

**Macon, Ga 31201**

Navicent Health Entities can be billed by providing the following information:

|  |  |  |
| --- | --- | --- |
| Corporate Number | Cost Center | Account Number |
|  |  |  |

Principle Investigator Signature