**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