



SCARBOROUGH HEALTH NETWORK RESEARCH ETHICS BOARD PROTOCOL AMENDMENT FORM

Please note, as of January 1st 2019, all researchers are required to have TCPS2 Certification. If you have not already done so, please provide your certificate.

| | | |
|---|--|--------------|
| SHN PROTOCOL NUMBER | | |
| LOCAL PRINCIPAL INVESTIGATOR | | |
| PROJECT TITLE | | |
| Signature of Principal Investigator: | | Date: |

| | | |
|---|---|----------|
| 1 | Date of amendment/version | dd/mm/yr |
| a | Amendment number | dd/mm/yr |
| b | Date amendment received by Principal Investigator/ Study Coordinator (Attach all supporting documentation with this form) Please include a summary of changes | dd/mm/yr |

| | | | |
|---|--|-----|--|
| 2 | The Patient Information and Consent Form requires modification based upon the protocol amendment | YES | |
| a | | NO | |
| b | If YES, a revised Patient Information and Consent Form is attached | YES | |
| | | NO | |
| c | If a revised Patient Information and Consent Form is not attached, please explain | | |

Submit signed original: Research Office, Scarborough Health Network, 3050 Lawrence Avenue East, Room 1.245, 1st Floor, Scarborough, Ontario, M1P 2V5