Ethical and Protocol Review Committee, College of Health Sciences, University of Ghana

EPRC Form 1A

*This form must be completed and duly signed by the **"Principal Investigator"** or **"Official Responsible"** designated for the research project, and sent with **EACH** submission of documents **(see submission checklist)**.*

Title of Protocol:

Type of Request:

Amendment(s) *(Tick appropriately if 'Type of Request' above is Amendment)*:

1. Addition Information to Protocol
2. Change of Study Site
3. Addition to Study Site
4. Change of Principal Investigator
5. Addition to Investigators

Others *(Specify)*:

Part I – Information on Principal Investigator

Title:
Last Name/Surname:
First Name:
Other Names (Maiden):
Institutional Affiliation:
Postal Address:
Digital Address *(if available)*:
Phone No. *(Official)*:
Phone No. *(Personal)*:
Email:

Part II – Information on Co-Investigator(s). For students these are the supervisors.

Co-Investigator/Supervisor 1

Title:
Last Name/Surname:
First Name:
Other Names (Maiden):
Institutional Affiliation:
Postal Address:
Digital Address *(if available)*:
Phone No. *(Official)*:
Phone No. *(Personal)*:
Email:

Co-Investigator/Supervisor 2

Title:
Last Name/Surname:
First Name:
Other Names (Maiden):
Institutional Affiliation:
Postal Address:
Digital Address (if available):
Phone No. (Official):
Phone No. (Personal):
Email:

Co-Investigator/Supervisor 3

Title:
Last Name/Surname:
First Name:
Other Names (Maiden):
Institutional Affiliation:
Postal Address:
Digital Address (if available):
Phone No. (Official):
Phone No. (Personal):
Email:

Co-Investigator/Supervisor 4

Title:
Last Name/Surname:
First Name:
Other Names (Maiden):
Institutional Affiliation:
Postal Address:
Digital Address (if available):
Phone No. (Official):
Phone No. (Personal):
Email:

Part III – Information on Funding Sources

Funding Organization:
Institutional Affiliation:
Postal Address:
Digital Address (if available):
Phone No. (Official):
Email:

Part IV – Information on Protocol

Nature of Protocol: Select Type if Academic:
Others (Specify):

Type of Study:
Clinical Trial Laboratory Studies Biomedical Studies Epidemiological Studies
Others (Specify):

Study Site(s)
Regions:
Districts:

Communities:

Facilities:

Total Budget (GHC): Duration of Study:

Start Date *(dd/mm/yyyy)*: End Date *(dd/mm/yyyy)*:

Have you submitted this protocol for ethical review and approval from any other institution?
If yes, which institutions have you submitted this to?

Outcome/Status of these other submissions *(State per submission)*:

DECLARATION BY APPLICANT

I certify that all documents (i.e. applications, statements, reports, and any other information) required to be submitted as a condition to obtaining Ethical Approval from the Ethical and Protocol Review Committee of the College of Health Sciences are true, accurate, and complete. *(Tick)*

Signature: ..... Date *(dd/mm/yyyy)*:

FOR OFFICIAL USE

Protocol has met the minimum requirements for submission:
Officer Receiving:

Signature: ..... Date *(dd/mm/yyyy)*: