VA Maryland Health Care System
Human Research Protection

COMPLAINT INFORMATION FORM

Date:_____Time:_____

Regarding whom: _____

Contact person:_____

Keep contact person confidential: _____No _____Yes

Phone number of contact:_____

Study number:_____ Principal Investigator:_____

Issue:_____

_____

_____

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Date and time IRB and ACOS (or other required notifications)_____

Dates of follow-up:_____

Comments:_____

_____

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_____

Complaint initially received by:_____