Institutional Review Board:
Procedures for the Review of Research Involving Human Subjects

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A. INTRODUCTION

Pursuant to the National Research Act (P.L. 93-348§212a) and Title 45 of the Code of Federal Regulations (CFR) Part 46.103, Indiana State University (ISU) maintains an Institutional Review Board (IRB) and has created written policies and procedures to govern its actions. As an institution of higher education, Indiana State University has established an IRB charged with assuring the protection of the rights and welfare of human subjects participating in research. Therefore, the IRB is required to review all research involving human subjects prior to the conducting of any research. This manual has been prepared to assist all members of the university community in complying with the stated policy and procedures of the institution regarding research involving human subjects. Appendixes contain forms, instructions, and other guidelines to assist the researcher, the various academic departments and other units of ISU, and the IRB in carrying out the review process.
This manual is believed to be in full compliance with all applicable Federal and state laws and regulations. This manual supersedes all previous versions. Revisions will be issued, as needed, reflecting changes in federal and state laws and regulations and changes in University procedures, which experience shows to be needed or desirable. Comments from users of this manual are welcome and will be given full consideration in the preparation of revisions and changes in procedures for the review of research involving human subjects. Please forward your comments to the Indiana State University IRB administrator at research@indstate.edu.

A.1 General Distribution of Responsibility

Any activities in which an ISU faculty member, staff member, or student investigates or collects information on living humans for research or related activities may be considered as "involving human subjects." It is the responsibility of each investigator to seek review by the IRB for any study involving human subjects prior to beginning the project.

ISU's IRB is responsible for the review of research or related activities involving human subjects. The respective authorities and duties of the IRB are described in this policy manual.
Consistent with federal regulations, the chief research officer (CRO) appoints members to the IRB.

The IRB administrator is responsible for managing the application review process, serving as a liaison with funding agencies, managing human subjects research training, maintaining records, reporting to federal entities, and ensuring ongoing regulatory compliance.

A.2 Abbreviations and Definitions Used in Policy and Procedures

Federal regulations and university policy use the following abbreviations:

CFR Code of Federal Regulations
FDA Food and Drug Administration
DHHS U.S. Department of Health and Human Services
OHRP Office for Human Research Protection
ISU Indiana State University
IRB Institutional Review Board
CRO Chief Research Officer
PI Principal Investigator
OSP Office of Sponsored Programs

URC University Research Committee
ORI U.S. Dept. of Health and Human Services - Office of Research Integrity
EAP Executive, Administrative, and Professional staff

Federal regulations and university policy define various terms in regard to protection of human research subjects. 45 CFR 46 is the body of regulations promulgated by DHHS. Most projects at ISU fall under these regulations. 45 CFR 46 includes the following definitions:

A.2.1 Definitions used by the Department of Health and Human Services, New Common Rule

(1) Secretary means the Secretary of Health and Human Services and any other officer or employee of the DHHS to whom authority has been delegated.

(2) Department or agency head means the head of any Federal department or agency, for example, the Secretary of HHS, and any other officer or employee of any Federal department or agency to whom the authority provided by these regulations to the department or agency head has been delegated.

(3) Research means a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge. Activities which meet this definition constitute research for purposes of this policy, whether or not they are conducted or supported under a program which is considered research for other purposes. For example, some demonstration and service programs may include research activities.

(4) Human subject means a living individual about whom an investigator (whether professional or student) conducting research:

   a. Obtains information or bio specimens through intervention or interaction with the individual, and uses, studies, or analyzes the information or bio specimens; or
      i. Obtains, uses, studies, analyzes, or generates identifiable private information or identifiable bio specimens.
   b. Intervention includes both physical procedures by which information or bio specimens are gathered (e.g., venipuncture) and manipulations of the subject or the subject's environment that are performed for research purposes.
   c. Interaction includes communication or interpersonal contact between investigator and subject.
   d. Private information includes information about behavior that occurs in a context in which an individual can reasonably expect that no observation or recording is taking place, and information that has been provided for specific purposes by an individual and that the individual can reasonably expect will not be made public (e.g., a medical record).
   e. Identifiable private information is private information for which the identity of the subject is or may readily be ascertained by the investigator or associated with the information.
   f. An identifiable bio specimen is a bio specimen for which the identity of the subject is or may readily be ascertained by the investigator or associated with the bio specimen.

(5) Minimal risk means that the probability and magnitude of harm or discomfort anticipated in the research are not greater in and of themselves than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests.

(6) Vulnerable population means children, prisoners, pregnant women, mentally disabled persons, economically or educationally disadvantaged persons, individuals who are unable to give informed consent due to a physical or mental condition, or individuals whose circumstances may make them especially vulnerable to coercion (e.g., probationers).

(7) Prisoner means any individual involuntarily confined or detained in a penal institution. The term is intended to encompass individuals sentenced to such an institution under a criminal or civil statute, individuals detained in other facilities by virtue of statutes or commitment procedures that provide alternatives to criminal prosecution or incarceration in a penal institution, and individuals detained pending arraignment, trial, or sentencing. Prisoners receive additional protections under 45 CFR 46, Subpart C.
(8) Child means a person who has not yet attained the age of consent to treatments or procedures involved in the research, under the applicable laws of the jurisdiction in which the research will be conducted. Children receive additional protections under 45 CFR 46, Subpart D.
(9) Parent means a child's biological or adoptive parent.
(10) Guardian means an individual who is authorized under applicable state or local law to consent on behalf of a child to general medical care.
(11) Identifiable Bio specimen: An identifiable bio specimen is a bio specimen for which the identity of the subject is or may readily be ascertained by the investigator or associated with the bio specimen.
(12) Assent means a child's affirmative agreement to participate in research. Mere failure to object should not, absent affirmative agreement, be construed as assent.
(13) Permission means the agreement of parent(s) or guardian to the participation of their child or ward in research.
(14) Adverse effect means an undesirable and unintended, although not necessarily unexpected, result of therapy or other intervention (e.g., subject becomes upset following completion of a depression questionnaire, subject experiences intestinal bleeding associated with aspirin therapy) that is directly or indirectly due to participation in a research study.

Some studies may fall under the regulations promulgated by the FDA (21 CFR 50). These will generally be studies that involve the testing of an investigational medication or a medical device. Refer to 21 CFR 50 for specific definitions regarding these studies. Some FDA definitions differ from the above DHHS definitions.

A.2.2 Definitions used by Indiana State University

In addition to definitions promulgated by federal agencies, ISU policy uses the following definitions:

(1) IRB Administrator is the individual who serves as OHRP's primary institutional contact person and has administrative responsibilities for the IRB.
(2) Principal Investigator is the person who leads the project and is ultimately responsible for all aspects of it.
(3) Faculty Sponsor is the faculty member who serves as a supervisor of student research and is considered co-investigator on student research protocol. The faculty sponsor accepts responsibility that the protocol follows ethical standards of research, adheres to federal guidelines, and includes all required information for review. Faculty sponsors must be on current appointment as faculty members at Indiana State University and must have satisfied all requirements of Indiana State University to serve in the role of faculty sponsor.
(4) Student project means a study or activity in which a student investigator (individually or as part of a group) gathers or analyzes information in a systematic manner, primarily for pedagogical purposes. It is not intended to contribute to generalizable knowledge and is not to be published (including publication on the Internet), presented, or archived. Research conducted for a master's thesis or doctoral dissertation does **not** fall under this definition.

(5) Institutional research is a study conducted by ISU staff that is designed to obtain information to assist in the administration of the university. Institutional research provides information for administrative planning, policy making, decision making, and includes examinations of institutional effectiveness. It is not intended to produce generalizable knowledge.
(6) Training refers to a process approved by ISU, and required by federal regulations, to instruct investigators in the conduct of research involving human subjects.

A.3 General Information on Submitting Materials to the IRB

PIs should submit all new applications, modification requests, continuation requests, completion of research activities reports, and reports of problems involving risk, adverse effects, and non-compliance via IRBNet. Refer to Appendix 1 for more information on submission materials and for copies of the forms. IRBNet will send a notification to the IRB chairperson, vice chairperson, and the administrator when the PI submits materials within IRBNet. The IRB chairperson, vice chairperson, or designated IRB member will review the application for completion, and, once the application has been deemed complete, determine the level of review required. The IRB chairperson, vice chairperson, or designated IRB member will correspond directly with the PI within IRBNet regarding the submission. Correspondence of the PI regarding revisions to the submission materials or questions must be conducted through IRBNet.

Reports of adverse events must be reported immediately via phone or e-mail to the IRB chairperson or vice chairperson. A written report of the adverse event using the Adverse Incident Report must then be submitted to the IRB via IRBNet within five (5) working days after first awareness of the problem.

B. RESPONSIBILITIES AND ACTIONS OF THE INSTITUTIONAL REVIEW BOARD

B.1 Composition of the IRB and Appointment of Members

Federal regulations require that the IRB be composed of at least five (5) members (45 CFR 46.107). The IRB Administrator may serve as an ex-officio member without vote. Representation will include: (a) at least two members whose primary concerns are in scientific areas, such that both social and behavioral sciences and biomedical sciences are represented; (b) at least one member whose primary concerns are in non- scientific areas; and (c) a community representative who is not otherwise affiliated with ISU nor a member of the immediate family of an ISU employee. One member or alternate must be able to act as an advocate for children, by virtue of experience and education. One member or alternate must be able to act as an advocate for prisoners, by virtue of experience and education. These advocates may be the same individual or different individuals. In addition, the membership shall include men and women, as well as representation of racial and ethnic minority groups. All IRB members and alternates shall serve an initial one-year probationary term with service beyond the probationary period in three-year terms, which are staggered, and they may be reappointed for consecutive terms.

If a member or alternate leaves the university or goes on leave for one year or more, then the CRO will appoint a replacement for the period of leave or for the remainder of the member or alternate's term, whichever is applicable. This replacement will be serving in a probationary capacity.

The IRB chairperson will be appointed by the CRO. They will serve a three-year term with each year of that term being a renewable contract between the individual and the CRO, and they may be reappointed for consecutive terms. Similarly, the IRB vice chairperson will be appointed by the CRO with input from the chairperson. They will serve a three-year term with each year of that term being a renewable contract between the individual and the CRO, and they may be reappointed for consecutive terms. If either the IRB chairperson or vice chairperson takes a sabbatical, other leave of absence, or leaves the university, the CRO may appoint a replacement for the period of leave or for the remainder of the chairperson's or vice chairperson's term, or appoint a new chairperson or vice chairperson for a three-year term. The current membership list is kept on file by the IRB administrator, and is open to inspection by any employee or student of ISU. Additionally, a current membership list is posted on the IRB website along with the meeting schedules.

B.2 Responsibilities and Actions of the IRB Chairperson

The following actions are the responsibility of the chairperson of the IRB. They shall have the administrative assistance of the IRB administrator or an individual designated by the IRB administrator in carrying out these duties:

- Call each regular meeting of the IRB and provide copies of review materials and other items of business to each board member at least five (5) working days before the meeting.
- Maintain records of all IRB proceedings, applications, and approved projects. Approved project files will be maintained for the period required by the funding agency, if applicable. In any case, records shall be maintained for at least three (3) years from the date of termination of the project. Records will be maintained in a secure location with access limited to the IRB administrator and associated staff, the CRO, and IRB members and alternates.
- Provide advice and counsel on behalf of the IRB to those requesting assistance with the preparation of applications; those requesting information about the protection of human research subjects; and to those inquiring about the policies, procedures, and actions of the IRB.
- Post a letter informing each PI of the IRB's decision and actions after initial, continuation, modification, adverse event review, or upon any other action taken by the IRB.
- Notify the CRO of IRB actions regarding applications (approved, disapproved, pending, and withdrawn) via records retained.
- Notify the IRB, IRB administrator, and CRO of any unanticipated injuries or problems involving risks to subjects or others.
- Notify the IRB Administrator of any serious or continuing noncompliance with the regulations or requirements of the IRB (including, but not limited to noncompliance resulting from research fraud and/or misconduct), and any suspension or termination of IRB approval of research.
- Notify the IRB at its regularly scheduled meetings of all findings of expedited review procedures, and granting of exemptions.
- Monitor changes in federal guidelines and alert the CRO and IRB Administrator if written policies and procedures need to be revised.

- Delegate to the vice chairperson or another IRB member or alternate any new applications, continuation requests, modification requests, or adverse event reports that are submitted by members of the chairperson's department or are projects in which the chairperson is involved.
- Delegate to the vice chairperson other duties and responsibilities as appropriate.
- When the chairperson is unavailable, the vice chairperson assumes the responsibilities of the chairperson.

B.3 Meetings and Quorums

A quorum is required to convene a meeting of the IRB. A quorum consists of at least a majority of members (or their alternates) present at the meeting, either in person or via a conference call. At least one member, or alternate who is a nonscientist, must be present at the meeting. When members or alternates are associated with a project being reviewed, they are ineligible to vote on the project. However, the IRB may ask them to provide information about the project or they may excuse themselves from the meeting during the review. Conflicts of interest should be noted in the IRB meeting minutes.

Should the quorum fail during a meeting (e.g., loss of a majority through recusal of members with conflicting interests, early departures, absence of a nonscientist member or alternate), the IRB may not take further actions or votes until the quorum is restored. Alternate members of the board may be invited to each meeting and may participate in the discussion of agenda items, including reviews, although if they are not serving in a member's place, they are not be eligible to vote.

The chairperson will convene meetings of the board for review of new applications, modification requests, continuation requests, and suspension or termination of IRB approval. The meeting schedule shall be posted on the IRB website.

B.4 Functions and Operations of the IRB

- Conduct initial and continuing review of research with human subjects and report the findings and actions to the PI in writing;
- Determine which projects require more than an annual review and which projects require verification (from sources other than the investigators) that no material changes have occurred since the previous IRB review. Considerations used to make these determinations include the absolute risk to the subject, whether the risks outweigh the benefits, and prior conduct of the investigator(s) regarding the protection of human research subjects.
- Review proposed changes in research activities to ensure that the protection of human research subjects is maintained.
- Investigate any actual or suspected adverse event or incident of noncompliance.
- Observe project activities at any point to ascertain whether human subject protections are implemented so as to reduce the likelihood of an adverse event or noncompliance.

B.5 Review of Research

In conducting the review of research, the IRB shall follow the regulations stated in 45 CFR 46.109 and 45 CFR 46.110, and 45 CFR 46.101(b).

B.6 Approval of Research

Requirements to be met for approval are listed in the Reviewer Checklist in Appendix 2. These requirements are described in 45 CFR 46.111. In order to approve research covered by stated regulations, the IRB shall determine that all of these requirements have been met.

B.7 Actions and Authority of the IRB

For applications undergoing review by the full board, action on any of the options listed below requires a majority vote of the quorum. Action to require revision of an application includes the option of empowering the chairperson, vice chairperson, or designated IRB member to accept revisions on behalf of the IRB or to require reconsideration of the application as revised at a subsequent meeting.

B.7.1 Actions Regarding Approval of Applications Requiring Full Board Review

The IRB may reach any of the following determinations with respect to any proposed project:

- Approve application as submitted.
- Approve pending changes. The IRB determines the changes that are required for approval and these are communicated in writing to the PI. The PI submits the changes to the IRB chairperson. The chairperson, vice chairperson, or designated IRB member may approve the application on behalf of the IRB if the changes meet the requirements described in the written communication with the PI.
- Require revisions and resubmission to the IRB.
- Request consultant review. At any point during the formal review and/or proceeding(s), the IRB chairperson, vice chairperson, or the IRB may determine that someone not on the IRB with relevant expertise needs to be consulted to address research issues, as they relate to the protection of human research subjects. The consultant shall not be involved in the proposed project. In some cases, the identity of the consultant may need to remain confidential if there is any question that there could be problems should the PI know the identity of the consultant.
- Disapprove the application as submitted: When a project is disapproved, the PI may revise the proposal in accordance with IRB recommendations; discuss the project with the IRB chairperson or respond in writing; or withdraw the proposal application.
- The IRB Full Board Review may result in a determination that future modifications to the protocol may be handled by an Expedited Review process.

B.7.2 Actions Regarding Approval of Applications Using Expedited Review Procedures

The IRB may reach any of the following determinations with respect to any proposed project:

- Approve application as submitted.
- Require revisions and resubmission to the IRB.
- Determine that the application requires a Full Board Review.

B.7.3 Actions Regarding Determining Applications as Exempt Review Procedures

The IRB may reach any of the following determinations with respect to any proposed project:

- Exempt application as submitted.
- Require revisions and resubmission to the IRB.
- Determine that the application requires either Expedited or Full Board Review.

B.7.4 Additional Actions and Authority of the IRB

- Consult with the CRO concerning matters of development and implementation of policies and procedures regarding the protection of human subjects and the training of ISU employees and students regarding the conduct of research involving human subjects.
- Suspend or terminate approval of research that is not being conducted in accordance with the requirements or that has been associated with unexpected serious harm to subjects. Any suspension or termination of approval shall include a written statement of the reasons for the IRB's action and shall be reported promptly to the CRO and the funding agency (if applicable).

C. RESPONSIBILITIES AND ACTIONS OF THE CHIEF RESEARCH OFFICER

C.1 Administrative responsibilities of the CRO

The CRO is administratively responsible for the implementation of the assurance to the Secretary of Health and Human Services. Procedures and actions of the CRO with respect to implementation of the assurance include, but are not limited to the following:

- Designate one or more IRBs for which sufficient provision has been made for staff and space needs in order to support the IRB's functions;
- Appoint members and alternates to the IRB;
- Appoint the IRB chairperson and vice chairperson;
- Monitor changes in federal guidelines and revise written policies and procedures in consultation with the IRB;
- Oversee initial training and continuing instruction of IRB members, the IRB administrator, university administrators, and any other personnel for whom federal regulations and ISU policy requires training regarding policies and procedures;
- Review research approved by the IRB in accordance with 45 CFR 46.112;
- Provide that research covered by the regulations will be reviewed, approved, and subjected to continuing review by the IRB;
- Ensure prompt reporting to the IRB, IRB administrator, appropriate university officials, OHRP, and any sponsoring federal department or agency head of any unanticipated injuries or problems involving risks to subjects or others, any serious or continuing noncompliance with the regulations or requirements of the IRB, and any suspension or termination of IRB approval of research;
- Provide a statement of principles governing the institution in the discharging of its responsibilities in protection of the rights and welfare of human research subjects;

- Provide of a list of IRB members to DHHS, identified by the requirements contained in 45 CFR 46.103(b)(3); and
- Provide satisfactory written assurance to the Secretary of Health and Human Services that the institution will comply with the requirements as set forth in the applicable federal regulations.

C.2 Actions of the Chief Research Officer upon Receipt of Notice of IRB Action from the Chairperson

- For externally funded projects approved by the IRB, the CRO, if they also approve the project for submission, will complete any documentation required by the funding agency, and send the documentation to the proper agency.
- The CRO may review, approve, or disapprove research that has been reviewed and approved by the IRB. The CRO may not approve research covered by these regulations that has not been approved by the IRB (45 CFR 46.112).
- If the CRO does not also approve projects approved by IRB, they will notify the IRB and the PI in writing of their action and of necessary subsequent action by the PI.
- Records of these actions will become part of the project file maintained by IRB.

C.3 Revisions of Policies and Procedures

The CRO, in consultation with the IRB, may institute any changes of policy and procedure for the review of research involving human subjects as may be consistent with currently applicable regulations, institutional requirements, and IRB experience. As changes occur in 45 CFR 46 and applicable portions of 21 CFR 50, they will be included in ISU policy and procedures by reference, without requiring separate action by the CRO. When DHHS issues new or revised policies or procedures, the IRB chairperson will consult with the IRB and draft a recommendation to the CRO regarding adoption.

The IRB administrator will maintain a current master copy of ISU policy, will provide a copy of any changes in ISU policy to all IRB members and alternates, and will update the IRB website. Additionally, the CRO shall determine the appropriate method of dissemination of policy and procedural changes to the ISU community.

D. RESPONSIBILITIES AND ACTIONS OF THE IRB ADMINISTRATOR

The IRB administrator will be designated by the CRO. The following actions are the responsibility of the IRB administrator:

- Retain ISU's Federal wide Assurance, copies of pertinent federal regulations, policies and guidelines related to the involvement of human subjects, as well as ISU's policies and procedures;
- Serve as an ex-officio member, without vote, on the IRB;
- Provide regulatory and ethical advice to PIs in preparation of application for research proposals involving human subjects and consent documents;
- Coordinate with grant and contract services regarding compliance on new, continuing, and competing proposals with human subjects regulations and policy;

- Arrange and oversee the training program for IRB members, IRB alternates, PIs, faculty, staff, and students on the ethical conduct of research involving human subjects;
- Educate members of the ISU community about changes to the IRB policy and procedures;
- Update the IRB website;
- Ensure that IRB records are being maintained appropriately and that records are accessible upon request, to authorized federal officials;
- Ensure all cooperating research sites in federally supported research have appropriate OHRP-assurances and provide certification of IRB approval of proposed research to the appropriate federal department or agency;
- Report to the IRB, CRO, and appropriate institutional officials any unanticipated injuries or problems involving risks to subjects or others, any serious or continuing noncompliance with the regulations or requirements of the IRB, and any suspension or termination of IRB approval of research; and
- Delegate responsibilities as appropriate.

E. RESPONSIBILITIES AND RIGHTS OF THE PRINCIPAL INVESTIGATOR

E.1 Responsibilities

The PI has primary responsibility for all aspects of the protection of human subjects on a given project, including:

- Consult with IRB chairperson or vice chairperson if they are unsure whether a study meets the federal definition of research with human subjects.
- Submit applications for review and approval prior to initiating research, and in accordance with ISU policy.
- Conduct the study in accordance with the ethical standards described in the Belmont Report, federal regulations, ISU policy, and the protocol as approved by the IRB.
- Begin research activities only after written approval or exempt determination by the IRB has been received. If the research is administered to an individual in an emergency or other situation before the study begins, the individual may not be considered a subject in the research. If the project involves new drugs or medical devices, FDA requirements must be satisfied.
- If changes are needed in an approved protocol, submit the proper documentation via IRBNet to modify the protocol and wait to receive written approval before implementing any changes.
- Submit requests for continuing review in accordance with the timeframe established by the IRB at the time of approval of the protocol.
- Report any unanticipated risks, physical or psychological harm, or other problems to the IRB chairperson or vice chairperson immediately upon becoming aware of them, in accordance with ISU Policy.
- Report to the IRB when the research project is completed (see ISU Policy). Retain signed informed consent forms and research materials for at least three years after the completion

of the research project. Some funding agencies may have different retention requirements, and the PI is responsible for understanding and complying with those policies.
- Make accessible all records for inspection and copying by a designated IRB member or the department or agency supporting the research.
- Keep certification for all investigators current regarding training to conduct research with human subjects, as required in ISU's policy.

E.2 Rights

- Applications shall be reviewed by the IRB in accordance with the ethical principles described in the Belmont Report, federal regulations, and ISU policy.
- When protocols are submitted, the IRB shall review the application in a timely manner as specified in the policy, barring any unforeseen and insurmountable problems.
- All decisions of the IRB shall be conveyed to the PI in writing via IRBNet.
- The PI may consult with the IRB chairperson or vice chairperson if they are unclear about the rationale for its decisions or if any questions arise at any time.

E.3 Responsibilities of the PI upon Leaving ISU

When a PI severs their employment with the institution, retire, cease research activities, or continue research activities at another institution, they must notify the IRB in writing as early in the process as possible. This will allow the IRB to close the active research file or take other appropriate actions. The PI is responsible for obtaining IRB approval at the new institution. If the research project will continue at ISU under another investigator, the PI must submit a Proposed Modifications Form via IRBNet, and the IRB will follow the review guidelines set forth in this policy.

F. PROCESS FOR IRB REVIEW AND APPROVAL OF RESEARCH

F.1 Levels of Review

This section describes the three possible levels of IRB review for studies that involve human research subjects.

F.1.1 Exemption Determination Review

F1.1.1 New Application

Research activities in which the involvement of human subjects constitutes no more than minimal risk and falls within one or more of the exemption categories described in 45 CFR 46.101 (see Exempt Review of Research form) may be eligible for exemption determination. The PI may request that the research application receive exemption determination by submitting Form B with their application within IRBNet. Only the IRB may determine that the proposed research meets the exemption criteria. Exempt review is conducted by the IRB chairperson or vice chairperson, or a designated IRB member who will verify level of review through the categories listed in the Exempt form (exempt research checklist) and consider the issues delineated in the reviewer checklist (Appendix 2), the informed consent information (Appendix 3), and local context issues. If the IRB chairperson is involved with the study or if the PI and IRB chairperson are from the same department or program, the IRB chairperson will designate the vice chairperson or another IRB member, who is not involved

with the project or from the same department, to review the study for exemption determination. Similarly, if the IRB vice chairperson is unable to review the study because they are involved in the project or from the same department as the PI, the IRB chairperson or another IRB member will review the study for exemption determination. The PI may expect written notification of the status of the project (i.e., exempt, additional information or revisions needed, or changing the level of review) within fifteen (15) business days following notification of the board action of "Forwarded" on a complete research application within IRBNet.

The IRB chairperson, IRB vice chairperson, or designated IRB member may take one of the following actions:

- Determine the research project as exempt and requiring no further IRB review, unless modifications are proposed which are outside the exemption categories. An exempt determination letter will be posted in IRBNet.
- Require additional information or revisions(s). The IRB chairperson, IRB vice chairperson, or designated IRB member will contact the PI via IRBNet to request the required additional information or modification(s). If the IRB chairperson, IRB vice chairperson, or designated IRB member is satisfied that the protocol meets the exemption criteria, the research project is determined to be exempt and an exempt determination letter is posted in IRBNet.
- Deny exemption determination. If the protocol does not fall within one or more of the exemption categories, as deemed by the IRB chairperson, IRB vice chairperson, or designated IRB member, the application is considered for expedited or full review.

F.1.1.2 Modification Request

If a study is determined to be exempt, the PI must request approval for any proposed modifications (see Proposed Modifications Form) to the research project's protocol or informed consent or assent forms that do not fall within the exemption categories. The modifications must be approved by the IRB prior to implementation.

F.1.1.3 Continuation Request

Once a study is certified as exempt, continuation reviews are not required.

F.1.2 Expedited Review

F.1.2.1 New application

Research activities, in which the involvement of human subjects involves no more than minimal risk and falls within one or more of the expedited review categories (see Form C), may be eligible for expedited review. The PI may request that the research application receive expedited review by submitting the Expedited Review Form with their application within IRBNet. Only the IRB may decide whether the proposed research meets the expedited review criteria requirements. Expedited review is conducted by the IRB chairperson or vice chairperson, and a designated IRB member who will verify level of review through the categories listed in the Expedited Review Form (expedited review research checklist) and consider the issues delineated in the reviewer checklist (Appendix 2), the informed consent information (Appendix 3), and local context issues. If there is a conflict of interest for both the chairperson and vice chairperson, two (2) designated IRB members will conduct the review.

All new applications will undergo a pre-review process to determine if all required contents and signatures are present. This pre-review process could take up to ten (10) business days. The IRB may ask the PI to make revisions to the protocol or informed consent procedures/documents following the pre-review process. Once the application is deemed complete, it will be forwarded for review, and the PI may expect notification of the status of their project within fifteen (15) business days following notification of a board action of "Forwarded" from IRBNet. The reviewers may exercise all of the authorities of the IRB, except they may not disapprove the research application.

Under the expedited review process, the reviewers may take one of the following actions:

- Approve the research application and decide on the length of time the study is approved (one year or less). A letter of approval and the informed consent or assent form with the IRB approval information is posted in IRBNet. (See Section J.1 for more information about the validation information.)
- Require additional information or revisions. The IRB chairperson, IRB vice chairperson, or a designated IRB member will contact the PI via IRBNet to request the required additional information or revisions. The reviewers may decide that one or both of them need to review the additional information or revisions. If the reviewers are satisfied that the protocol meets the IRB review criteria, the research project is approved for one year or less and a letter of approval is posted in IRBNet.
- Require a full review of the application. If the protocol does not fall within one or more of the expedited review categories, the reviewers have concerns about the rights and welfare of the subjects, or the additional information or modifications are extensive, the reviewers will forward the application for a full review. The PI will be notified via IRBNet that a full review is required and will be informed of the reasons for this decision. Additionally, the PI may be asked to revise the application prior to distribution of the application to the full IRB committee.

F.1.2.2 Modification Request for Previously Approved Projects

The PI must request approval for any proposed modifications to the research project's protocol or informed consent or assent forms. The modifications must be approved by the IRB prior to implementation.

- Modification requests to the protocol or informed consent or assent forms for research projects that were previously approved through the expedited review process may be reviewed under the expedited review process. The PI will submit the Proposed Modification Form for review via IRBNet. For minor modifications that do not change the substance of the project, the level of risk to the subjects, or the level of review required, the IRB chairperson, vice chairperson, or a designated IRB member may conduct the review. For more than minor modifications, the review process is the same as for a new application. The timeline is the same as for a new application. The reviewers may take one of the following actions:
- Approve the requested modifications. A letter of approval of the requested modifications will be posted in IRBNet.
- Require additional information or modifications. The IRB chairperson, IRB vice chairperson, or designated IRB member will contact the PI via IRBNet to request the required additional information or modification(s). The reviewers may decide that one or both of them need to review the additional information or modifications. If the reviewers are satisfied that the

requested modifications meet the IRB review criteria, the modifications are approved and a letter of approval is posted in IRBNet.

- Require a full review of the modification request. If the modifications change the study protocol such that the study no longer falls within one or more of the expedited review categories, the reviewers have concerns about the rights and welfare of the subjects, or the additional information or modifications are extensive, the reviewers will forward the modification request for a full review. The PI will be notified via IRBNet that a full review by the IRB is required and will be informed of the reasons for this decision. Additionally, the PI may be asked to revise the modification request prior to distribution of the modification request to the full IRB.

F.1.2.3 Continuation Request

Research projects, which are approved under the expedited review process, are approved for an identified and very specific duration. As such, continuing research activities beyond the approval period requires submission of a Continuation Request.

A continuation request for a research project that was approved under expedited review procedures may be reviewed under the expedited review process. The PI will submit a continuation request form and appropriate documents. The IRB chairperson, IRB vice chairperson, or a designated IRB member will verify the appropriate level of review for the continuation request, and will inform the PI via IRBNet if a full review is needed. For continuation requests without proposed modifications or with only minor modifications that do not change the substance of the project, the level of risk to subjects, or the level of review required, the IRB chairperson, IRB vice chairperson, or a designated IRB member may conduct the review. For continuation requests with more than minor modifications proposed, the expedited review process, timeline, and review actions are the same as for a new application.
If the PI fails to request a continuation or submit requested information, IRB approval will be terminated on the approval expiration date. All research activities, including data analysis, must cease, unless the IRB finds it is in the best interest of the individual subjects to continue participating in the research interventions or interactions. A notification will be sent to the PI via IRBNet, and if appropriate, the letter will be sent to the funding agency.

F.1.2.4 Completion of Research

For a completed research project that has undergone expedited review, the PI must submit a completion of research form via IRBNet on or before the IRB approval expiration date. This will allow the IRB to close the active file. IRBNet will notify the PI of the expiration prior to expiration of IRB approval.

F.1.2.5 Informing IRB members of Expedited Reviews

At each regular IRB meeting, the IRB chairperson will provide the IRB with a list of new research applications, modification requests, and continuation requests that have been submitted or approved through the expedited review process.

F.1.3 Full Review

F.1.3.1 New application

Research activities in which the involvement of human subjects involves more than minimal risk, does not fall within one or more of the exemption categories (Exempt Research Form) or expedited review categories

(Expedited Research Form), or involves certain vulnerable populations (e.g., prisoners) must undergo a full IRB review Prior to distribution to the IRB members, the IRB chairperson, IRB vice chairperson, or a designated IRB member will review the application and may ask the PI to make revisions to the protocol or informed consent procedures. Once revisions, if needed, are received, a full review will be scheduled for the next regular IRB meeting or a special meeting may be called. The application materials will be distributed to the IRB members at least five (5) working days before the meeting via IRBNet. The PI may attend the meeting in which their application will be reviewed. If the PI is a student, the faculty sponsor must attend as well.

A schedule of the IRB meetings, along with submission deadlines for new applications, modification requests, and continuation requests requiring full review, is posted on the IRB website. The PI is responsible for submitting the required materials via IRBNet, by the deadline, typically ten (10) working days prior to a scheduled meeting. Submission of materials by the deadline does not guarantee a full review will be conducted at the next meeting. Reasons for delaying review until the next meeting may include an already full agenda or the protocol requires revisions prior to review. Therefore, the IRB recommends that the PI submit the materials as early as possible. Under the full review process, the IRB will discuss issues delineated in the reviewer checklist (Appendix 2) and the informed consent form information (Appendix 3), as well as issues related to the local context. The IRB may take one of the following three actions:

- Approve the research application and decide on the length of time the study is approved (one year or less from the date of the convened meeting at which the IRB reviewed and approved the proposal). A letter of approval and the informed consent or assent form with the IRB approval information will be posted in IRBNet
- Require additional information or modifications. During the IRB meeting, the IRB members may ask the PI for additional information. If the PI does not have the additional information available at the meeting, the PI will forward this information via IRBNet to the IRB chairperson or IRB vice chairperson as soon as possible. Additionally, the IRB may require that revisions be made. At the conclusion of the review, the IRB will decide whether:
- The IRB chairperson, IRB vice chairperson, or designated member may review the additional information or revisions to ensure that they meet the IRB requirements and approve the application, if appropriate. If the additional information or revisions are not sufficient, the IRB chairperson, IRB vice chairperson, or designated IRB member may continue to work individually with the PI until the IRB requirements are met. The IRB may require that the additional information or revisions be reviewed at the next IRB meeting. The PI may be present at the meeting.
- Disapprove the research application. A letter is posted in IRBNet describing the reasons the research application was not approved. The PI may revise the research application in accordance with IRB recommendations; discuss the reasons for disapproval with the IRB chairperson or a designated IRB member; or withdraw the research application.

F.1.3.2 Modification Request of a Previously Approved Protocol

The PI must request approval for any proposed modifications to the research project's protocol or informed consent or assent forms. This request must be submitted by the established deadlines for each monthly meeting, in order to receiving consideration. The modifications must be approved by the IRB prior to implementation.

Modification requests to the protocol or informed consent or assent forms for research projects that were previously approved through the full review process may be reviewed under the expedited review process if the requested modifications are minor (see Modification Request under the discussion of Expedited Reviews, above), otherwise, a full review process will be used. The PI will submit a modification request form via IRBNet and the IRB chairperson, IRB vice chairperson, or a designated IRB member will decide the appropriate level of review for the modification request. The PI will be informed of the level of review required. For modification requests, which can be reviewed under the expedited review process, see the modification request section under expedited review process. For modification requests that require a full review, prior to distribution to the IRB members the IRB chairperson or a designated IRB member will review the application and may ask the PI to make revisions to the protocol or informed consent procedures. Once revisions, if needed, are received, a full review will be scheduled for the next regular IRB meeting or a special meeting may be called. The modification request will be distributed to the IRB members at least five (5) working days before the meeting. The PI may attend the meeting in which their modification request will be reviewed. If the PI is a student, the faculty sponsor must attend as well.

The IRB may take one of the following actions:

- **Approve the requested modifications.** A letter of approval of the requested modifications is posted in IRBNet. If the modifications involve the informed consent or assent form, the appropriate revised form with the IRB approval information will also be posted in IRBNet.
- **Require additional information or modifications.** During the IRB meeting, the IRB members may ask the PI for additional information. If the PI does not have the additional information, the PI will forward this information via IRBNet to the IRB chairperson or IRB vice chairperson. Additionally, the IRB may require that revisions to the modifications be made. At the conclusion of the review, the IRB will decide whether:
- The IRB chairperson, IRB vice chairperson, or designated IRB member may review the additional information or modifications to ensure they meet the IRB requirements and approve the application, if appropriate. If the additional information or modifications are not sufficient, the IRB chairperson, IRB vice chairperson, or designated IRB member may continue to work individually with the PI until the IRB requirements are met or request that the IRB continue its review at the next meeting, or
- The IRB should require that the additional information or modifications be reviewed at the next IRB meeting. The PI may be present at the meeting.
- **Disapprove the modification request.** A letter is posted in IRBNet describing the reasons the modification request was not approved. The PI may revise the modification request in accordance with IRB recommendations; discuss the reasons for disapproval with the IRB chairperson, IRB vice chairperson, or designated IRB member; or withdraw the modification request.

F.1.3.3 Continuation Request

Research projects that are approved under the full review process will require continuation review at a specified interval, unless otherwise specified under federal regulations.

A continuation request for a research project that was approved under the full review procedures may be reviewed under the expedited review process if the research project meets the requirements listed in the expedited review category form; otherwise a full review will be required.

According to federal guidance, “a research project that was not eligible for initial review under an expedited review procedure usually will not qualify for an expedited review procedure at the time of continuing review, except in the following limited circumstances:

- The research project involves only activities described by expedited review categories (8) or (9); or
- Research project previously approved by the IRB at a convened meeting progresses to the stage where all of the remaining human subjects research activities involve no more than minimal risk to the subjects and fall within the scope of one or more of expedited review categories (2) through (7).” (Continuing Review Guidance, 2010)

The PI will submit a continuation request via IRBNet and the IRB chairperson, IRB vice chairperson, or a designated IRB member will decide the appropriate level of review for the continuation request. The PI will be informed of the level of review required. For expedited reviews, see the section on Continuation Review. For full reviews, the review process and review actions are the same as for a new application.
If the PI fails to request a continuation or submit requested information, IRB approval will be terminated on the approval expiration date. All research activities, including data analysis, must cease unless the IRB finds it is in the best interest of the individual research subjects to continue participating in the research interventions or interactions. A notification will be sent to the PI via IRBNet, and if appropriate, a letter will be sent to the funding agency (with assistance by the director of the Office of Sponsored Programs and/or IRB Administrator, who supports investigators by serving as a liaison with the federal government).

F.2 Length of IRB Approval

Typically, the IRB approves a research study or continuation request for one year. However, approval may be granted for less than one year in some circumstances, which may include, but are not limited to, high-risk protocols, projects involving unusual types of risk to subjects, projects involving vulnerable subjects (e.g., prisoners), and projects conducted by a PI who has previously failed to comply with IRB requirements.

F.3 Verification of Sources other than the PI

Some projects may require verification from sources other than the PIs that no material changes have occurred since previous IRB review. The criteria for determining which studies may need outside verification include, but are not limited to complex projects involving unusual levels or types of risk to subjects; projects conducted by PIs who previously failed to comply with 45 CFR 46 or the requirements or determinations of the IRB; and projects where concern about possible material changes occurring without IRB approval have been raised based on information provided in continuing review reports or from other sources.

F.4 Preparation of Public Use Data Files

Many funding agencies require or recommend that projects produce public use data files. If the PI knows that a public use data file will be created, they must indicate this on the initial application (Form A). Once the project is completed, the PI shall submit the proposed public use data file to the IRB for inspection. The funding agency may provide guidance in creation of public use files. The PI should provide this information to the IRB when submitting the protocol to prepare a public use data file. If the PI does not initially plan to develop a public use data file, once the determination to develop a public use data file is made, they will need to submit a modification request to the IRB.

For the IRB to classify the file as a public use data file, at least one (1) of the following situations must apply:

- The data were anonymous when originally collected or data were collected from unknown persons, or
- The data were collected from identified persons, but the file has been stripped of individual identifiers and any other information that may risk disclosure of any subject's identity.

When data have been collected from identified persons, the PI must consider the following elements in determining whether they have properly addressed the risk of disclosure of subjects' identity:

- All individual identifiers of each human research subject or any person named by any human research subject must be removed;
- All variables that can be surrogates for individual identifiers (e.g., street address of subject) must be removed;
- To remove the possibility of identification when a human research subject is in a small subgroup within the sample, it may be necessary to collapse or combine categories of a variable. For example, detailed breakdowns of religious denomination in a survey question, ICD-9 codes, or medical procedure codes may need to be collapsed into fewer categories;
- Delete or mask, as described above, any variable that a secondary user may employ to identify any research subject. For example, the PI may need to assign a new subject ID to each individual if the original subject ID contained identifying information, such as letters from the last name or part of the date of birth;
- Use statistical methods to add random variation to variables that cannot otherwise be masked. For example, a data file may contain a combination of public and private information on a relatively small sample, perhaps demographic characteristics and salary of a public official, along with attitudinal information. The income variable may need to be altered so that it cannot be combined with the demographic characteristics to enable identifying the individual and thereby risking disclosure of private information. This option should be used only if other techniques do not work, because it may compromise the integrity of the data.

ISU may post information on the OSP website regarding the following types of public use data files: (1) a list of all data files created by ISU investigators that have been certified for public use, and (2) a list of approved sources of publicly available data. The purpose of the first list is to allow investigators at other universities or organizations to be informed that the ISU IRB has certified that a specific data file is a public use data file, even if it is available from another source (e.g., the Inter-university Consortium for Political and Social Research). The primary purpose of the second list is to inform ISU investigators that any data file obtained from these sources is certified as a public use data file and thus does not require IRB review.

G. PROBLEMS INVOLVING RISK, ADVERSE EFFECTS, AND NONCOMPLIANCE

G.1 Guidelines for Defining Problems to be Reported

Unanticipated problems involving risks to subjects or others and adverse effects need to be reported to the IRB. Adverse effects may be directly or indirectly related to the research and may be expected or unexpected.

The following examples illustrate what needs to be reported:

- **Unanticipated problem involving risk to subjects**: The laptop computer which has identifying information about research subjects is stolen.
- **Unanticipated problem involving risk to others:** The research assistant involved in the project is inadvertently exposed to a low level of radiation
- **Expected adverse effect:** Subject A becomes upset when asked about feelings regarding prior sexual abuse. The subject is referred for counseling
- **Unexpected adverse effect:** Subject B becomes agitated and angry when asked general non-invasive questions about the appropriateness of corporal punishment of children. The subject is referred for counseling.

The last two scenarios are examples of direct effects. An example of an indirect effect is if Subject A or B misses class or work due to the psychological conditions described.

- In general, the PI must report the following events to the IRB chairperson or IRB vice chairperson:
- Situations related to the protection of study data, such that there is an inadvertent breach of confidentiality
- Negative outcomes from unintentional or intentional deviations from research protocol or informed consent process (e.g., loss of privacy, loss of rights, damage to reputation, legal problems, academic failure)
- Unforeseeable events that occur during or after a research intervention, even if it is unclear whether they were actually caused by the intervention
- Known side effects of an intervention
- Allergic reactions (or other adverse reactions to medications, devices, or procedures)
- Complications from procedures (e.g., infection, abnormal EEG, psychological change)
- Complications from research-related tests (medical and psychological)
- Increase in seriousness of a primary condition or situation

G.2 Guidelines for Defining Noncompliance

Noncompliance includes, but is not limited to:

- Misuse or nonuse of approved informed consent forms or procedures
- Failure to submit protocols in a timely manner
- Breaking confidentiality, unless required by law (e.g., child abuse)
- Unapproved subject recruitment activities
- Failure to secure confidential records in the required manner
- Failure to report problems involving physical or psychological injury to subjects or others
- Falsifying or fabricating human subject research data, injuries, or other information
- Failure to report risks to subjects or others that exceed the protocol as approved
- Report from a subject of abuse by the PI or research staff
- Conducting research involving human subjects that has never been approved by the IRB
- Initiating changes to research protocols involving human subjects without prior IRB approval

- Continuing research activities beyond the IRB approval expiration date

Even though these types of events **must** be reported, the PI is encouraged to contact the IRB chairperson or IRB vice chairperson if anything occurs that causes concern regarding the protection of human subjects.

G.3 Reporting of Problems or Noncompliance by the PI

The PI must contact the IRB chairperson or vice chairperson via phone or e-mail immediately following an incident of injury, increase in risk, unanticipated risk, other adverse effects experienced by subjects or others involved in research, or incident(s) of noncompliance. Additionally, the PI must submit the form for Report of Unanticipated Problems, Adverse Events or Noncompliance via IRBNet as soon as possible thereafter, but no later than 5 working days after first awareness of the problem. The report will be reviewed by the IRB chairperson, IRB vice chairperson, designated IRB member(s), or the full IRB. If the incident is severe or increases the risk to subjects or others, the PI may be asked to suspend research activities pending further review by the IRB or CRO.

G.4 Investigations of Problems and Noncompliance

If any member of the IRB receives information about injuries to subjects, unanticipated problems involving risk to subjects or others, or serious noncompliance, through a source other than the PI or co-PI, they will immediately inform the IRB chairperson or vice chairperson. The IRB chairperson or vice chairperson may temporarily suspend IRB approval for a study, pending investigation, after learning of the problem, adverse effect, or noncompliance.

The IRB chairperson or vice chairperson may conduct an informal inquiry into allegations of problems or noncompliance to make the determination whether an investigative subcommittee should be formed. If, based upon the level of risk to the research participants and the seriousness of the allegation, the decision is made that no formal investigation is necessary, the IRB chairperson or vice chairperson will provide a report to be posted within IRBNet and to be filed with the confidential project records which details the allegation of problems, noncompliance, and any corrective actions. If, however, the determination is made that a formal investigation should be conducted, a subcommittee of the IRB consisting of the IRB chairperson or vice chairperson, an IRB member who is outside the PI's department, and another IRB member, who holds tenure and is outside the PI's department, will investigate the allegation of a problem involving risk to subjects or others, an adverse effect, or noncompliance. The IRB chairperson or vice chairperson will request an interview with the individual(s) alleging the problem, adverse effect, or noncompliance, unless the allegation was received in writing. The IRB chairperson or vice chairperson will share the results of this interview or written correspondence with the other members of the ad hoc committee, and they will decide how to proceed. The IRB chairperson or vice chairperson will notify the PI via IRBNet within five (5) working days that an allegation of problem, adverse effect, or noncompliance was received. Following the interview or upon receipt of a written allegation, the IRB chairperson or vice chairperson will request an interview with the PI and any other researchers involved, in order to assess the situation, require changes in the protocol, if necessary, and resolve the issues without further official action. The ad hoc committee members will decide if both need to be present at the interview with the PI and other researchers involved. If the ad hoc committee members are not satisfied with the results of the initial interview with the PI, they may expand the investigation. The ad hoc committee members may interview the research staff and any other persons who have relevant information, including

research subjects. The ad hoc committee will produce written summaries to the interviewed parties for comments, and written comments received will be included in the record of the investigation.

The ad hoc committee will prepare a report which includes a description of the investigative activities, how and from whom information was obtained about the problem(s), a list of those interviewed, a summary of records obtained, finding, basis of findings, and actions taken. Before the report is shared with the IRB and CRO, identifying information which may put the individual making the allegation at risk may be removed. The final report, which contains all identifying information, will be posted within IRBNet and will be filed with confidential project records.

Appropriate officials will be notified if problems are confirmed by the ad hoc committee. This may include institutional officials, OHRP, and/or funding agency (if applicable) officials.

G.5 Suspension or Termination of Approval of Research Activities

The IRB chairperson or vice chairperson may suspend a study at any point after receiving information regarding unacceptable and uncorrectable levels of risk or harm to the subjects or others or serious disregard on the part of the researcher to the policies and directives of the IRB. The chairperson or vice chairperson will promptly post a letter of this decision and the reason(s) for suspension of approval within IRBNet and provide an IRBNet message advising the PI(s), as well as the IRB administrator and CRO, of the posting. The CRO will notify OHRP and funding agency (if applicable) of the suspension or termination of approval.

Furthermore, the IRB chairperson or vice chairperson will call a meeting of the IRB to discuss the suspension of IRB approval and the IRB will decide whether (1) IRB approval should be reinstated with or without modifications, (2) suspension of IRB approval should be continued, or (3) IRB approval should be terminated. A letter will be posted within IRBNet with the outcome of the IRB meeting.

G.6 Reporting by ISU of Problems or Noncompliance

The IRB chairperson or vice chairperson will keep the CRO informed of reports by PIs or others of unanticipated problems involving risk to subjects or others, adverse effects, serious or continuing noncompliance, and suspension or termination of IRB approval.

The CRO will notify appropriate institutional officials, OHRP, and the Department or Agency head of the funding agency (if applicable) of unanticipated problems involving risk to subjects or others, unanticipated adverse effects, serious adverse effects that may have been expected, serious or continuing noncompliance, and the IRB suspension or termination of approval for research activities for any non-exempt human subjects research.

H. CONFLICTING INTERESTS

Several types of conflicting interests may arise in conducting research. Project personnel must report all such real or potential conflicts to the PI. The PI is responsible for making certain that no project personnel perform research tasks if there is likely to be a conflicting interest.

Conflicting interests apply to both funded and non-funded research. 45 CFR 46 does not directly address conflicts of interest, but the IRB is required to determine that information provided to potential and actual subjects regarding the research is objective regarding the risks and benefits. It is also required to determine whether risks of the research have been properly addressed in the protocol. If conflicting interests exist, then such objectivity and handling of risks can be compromised.

Such potential conflicting interests include, but are not necessarily limited to those discussed below.

H.1 Financial Conflict of Interest

Indiana Code 35-44-1-3 describes financial conflicts of interest on the part of public employees. Disclosure of any such conflicts must be made in writing. Federal policy covers Financial Conflicts of Interest in Research that is funded by DHHS, FDA, and NSF, among others.

As articulated in the Indiana State University Handbook section on Financial Conflicts of Interest, "The Chief Research Officer is responsible for developing policies to govern financial conflicts of interest in relationship to research or projects funded in whole or in part by external sponsors and in accordance with federal or state regulations" (912.2.4 Conflict of Interest in Research).

H.2 Intellectual Property

All investigators must adhere to ISU's policy regarding intellectual property claims.

H.3 Conflicts of Commitment

Conflicts of commitment arise when an investigator's time or other commitments to a project cannot be honored because of existing commitments to the university. All investigators must avoid such conflicts that may arise due to the conduct of a research project.

H.4 Dual Relationships

Dual relationships exist whenever one role of the investigator calls into question their ability to be objective about fulfillment of another role. While such dual relationships may involve financial conflicts of interest, many do not.

At ISU, the most common situations are likely to be those in which faculty recruit students for research projects. Faculty must not recruit students from their classes, unless the IRB grants approval for doing so. See IRB policy for a more detailed discussion of students as research subjects.

I. COOPERATIVE RESEARCH

Cooperative research projects are those projects which involve more than one institution. The official relationship between the two institutions is not relevant. Each institution is responsible for safeguarding the rights and welfare of human subjects and for complying with federal and institutional policies. See 45 CFR 46.114 for more information.

According to Federal regulations, 45 46.114(b)(1) any institution located in the United States that is engaged in cooperative research must rely upon approval by a single IRB for that portion of the research that is conducted in the United States. The reviewing IRB will be identified by the Federal department or agency supporting or conducting the research or proposed by the lead institution subject to the acceptance of the Federal department or agency supporting the research.

(2) The following research is not subject to this provision:

(i) Cooperative research for which more than single IRB review is required by law (including tribal law passed by the official governing body of an American Indian or Alaska Native tribe); or

(ii) Research for which any Federal department or agency supporting or conducting the research determines and documents that the use of a single IRB is not appropriate for the particular context.

(c) For research not subject to paragraph (b) of this section, an institution participating in a cooperative project may enter into a joint review arrangement, rely on the review of another IRB, or make similar arrangements for avoiding duplication of effort.

PI(s) at ISU who are conducting research at another institution are required to abide by ISU requirements, as well as the requirements of the other institution. The PI will need to request a letter of approval from other institution stating that the research may be conducted at the site and that those at the site agree to comply with ISU's IRB requirement for the protection of human subjects. If the other institution has an IRB, the PI may be required to seek its approval as well, or file a request to designate one of the institutions' IRB to review the research (e.g., IRB authorization agreement). For studies funded by DHHS the PI is responsible for ensuring all data collection sites within the cooperative research protocol have an approved DHHS assurance (e.g., Federal wide Assurance), and each will review the research separately or designate one of the institutions' IRBs to review the research (e.g., IRB authorization agreement).

When ISU is considered to be "engaged in research" (see OHRP guidance document "Engagement of Institutions in Research," October 16, 2008) but the PI is not associated with ISU, the PI must submit the following for review by the IRB via IRBNet: an application (Form A, and Forms B or C if applicable), a letter of support from a faculty member or EAP staff member at ISU who will sponsor the project, and a letter of approval from the IRB of the institution where the individual is at, unless the individual's

Institution does not have an IRB. The IRB will then complete the appropriate review process, based on the nature of the research project. ISU may choose to rely on the review of the PI's IRB, in which case both institutions would need to complete the IRB authorization agreement. When ISU is not "engaged in the research," the unaffiliated PI needs to obtain IRB approval at their institution and secure permission from an ISU official (e.g., department chairperson, dean, supervisor) to conduct the study at ISU.

J. INFORMED CONSENT

J.1 Informed Consent Requirements

Informed consent is an ongoing process, not just a form that is signed. Informed consent assures that potential subjects understand the nature of the research project and their participation and can make an informed, voluntary decision about participating or not participating in a research study. The language used to present the information needs to be appropriate for the targeted subject population. Researchers should keep in mind that

individuals have the right to participate or not participate in a study and those who decide to participate may withdraw their consent from the study at any time for any reason, without incurring negative consequences. The process of obtaining informed consent must comply with the requirements of 45 CFR 46.116. Documentation of informed consent must comply with 45 CFR 46.117. Unless changes to the informed consent process are approved by the IRB, the PI is responsible for ensuring that informed consent is obtained in writing from the subject or the subject's legally authorized representative (e.g., parent), is understandable to the subject (or representative), is obtained in circumstances that are not coercive and that offer the subject (or representative) sufficient opportunity to decide whether they will participate. If any subjects are members of certain vulnerable populations, 45 CFR 46 describes additional informed consent requirements.

The informed consent form checklist (Appendix 3) delineates the basic elements that must be included in an informed consent form. The checklist also provides additional elements that may need to be included in the informed consent form, depending on the nature of the research study. The informed consent process and documents in research studies that involve health information may need to include statements that meet the requirements of Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Section K.4 and Appendix 4). Informed consent forms should be written in second person (e.g., "You are invited to participate…"), with the exception of the signature section, which may be written in first person. Use of first person in the body of the informed consent may be interpreted as suggestive or coercive. The informed consent form may not include exculpatory language in which the subject or representative is made to waive or appear to waive any of the subject's legal rights, or releases or appears to release the PI, sponsor, or institution (or its agents) from liability for negligence. The person who signs the informed consent form must be given a copy as a reference.

Informed consent procedures must be delineated in the research description portion of the application to the IRB. Any waivers to the procedure or documentation must be requested, as well. For studies in which the documentation of informed consent is waived, a letter of invitation to participate, which includes the elements of informed consent, may be appropriate. Additionally, informed consent forms and assent forms, if applicable, must be submitted to the IRB for review. Once approved, the IRB will place IRB approval/exemption information on the informed consent or assent form. This information will include the IRB number, the approval date and the expiration date. The IRB number and approval and expiration dates must appear on the informed consent document. The PI may use the copy with the IRB approval information for distribution to potential subjects or the PI may type the information (i.e., "IRB#…, Approval date…, Expiration date…) at the end of the informed consent form.

J.2 Alterations to the Informed Consent Procedure

Federal regulations on informed consent do allow for modifications in the consent procedures and, under certain circumstances, informed consent may be waived entirely if the research meets certain conditions (see 45 CFR 46.116(e)(f)), which might include waiver of signature or written consent, consistent with survey or interview when signed consent raises risk. Note that such modifications and waivers are not allowed under FDA regulations. For more information on this topic, please see 45 CFR 46.116(e)(f) and Appendix 3.

J.3 Alterations in the Documentation of Informed Consent

Typically, informed consent must be documented through the use of a written informed consent form that has been approved by the IRB and signed by the subject or the subject's legally authorized representative. A copy must be given to the individual signing the form, which can be provided electronically or by printed copy. However, documentation of informed consent may be waived in some circumstances. See 45 CFR 46.117 and Appendix 3 for more information.

J.4 Research Involving Children

Research projects involving children as subjects typically require the written permission of one or both parents (see 45 CFR 46.408(b)) or guardian in accordance with the informed consent procedures delineated in the informed consent requirements. In addition to parental or guardian permission for a child to participate in a research study, the assent of the child may be solicited, assuming the child is capable of providing assent. To make this judgment, the IRB will consider the age, maturity, and psychological state of the targeted child population. Even if the children are capable of providing assent, the IRB may waive the assent requirement when consent requirements are waived (see CFR 46.116).

Typically, parental or guardian permission must be documented. However, a PI may request a waiver of the documentation of informed consent based on 45 CFR 46.117(c) (see Appendix 3 for information). Additionally, the IRB may determine that parental or guardian permission is not a reasonable requirement to protect subjects (e.g., neglected or abused children) and it may waive the consent requirements, provided that an appropriate mechanism for protecting the children who participate as subjects in the research is substituted and the waiver is not inconsistent with federal, state, or local law (45 CFR 46.408(c)).

K. PROTECTION OF CONFIDENTIAL INFORMATION

The PI is responsible for ensuring the privacy and confidentiality of all personally identifiable information from research subjects, except as required by law (e.g., child abuse) or allowed with written permission of the research subject. Data storage should be consistent with University policy (University Policy Library, Section 830, Data Security and Management) When appropriate, the informed consent document should outline those conditions under which data are not considered confidential (e.g., child abuse, criminal activity). Data collection and storage, and safeguards to ensure confidentiality must be delineated by the PI in the research description portion of the application to the IRB.

K.1 Storage and Retention of Confidential Records

The PI must store confidential hard copy information gathered from or about any research subject in a secure (locked) facility to which only the PI and authorized project staff have access. Electronic data shall be password-protected at the workstation or file level. If this level of protection is not feasible, electronic data should be stored on removable media.

Confidential information must not be stored at the study site (e.g., hospital, prison, school) unless the PI is assured in writing that no one outside of the study at the research site has access.

K.2 Certificate of Confidentiality

For studies, whether funded or not funded, in which data are being collected about sensitive issues, the PI may obtain from the appropriate Federal agency an advance grant of confidentiality, known as a Certificate of Confidentiality that will provide protection of research data against subpoena. Sensitive issues include, but are not limited to, the collection of information falling into one or more of the following categories:

- information relating to sexual attitudes, preferences, or practices;
- information relating to the use of alcohol, drugs, or other addictive products;
- information pertaining to illegal conduct;
- information that if released could reasonably be damaging to an individual's financial standing, employability, or reputation within the community;
- information that would normally be recorded in a patient's medical record, and the disclosure of which could reasonably lead to social stigmatization or discrimination;
- information pertaining to an individual's well-being or mental health;
- other information that is not listed here may also be considered sensitive, given specific cultural or other factors.

Sensitive information may exist in a number of forms, including, but not limited to, survey responses, medical or other records, results of medical or psychological tests, or responses to experiments.
For information on how to apply for a Certificate of Confidentiality, contact the IRB administrator.

K.3 Access to Confidential Records

The university has the right of access to the supporting records for all research at the university or supported by university-sponsored funds, provided such access to the records shall be for reasonable cause, at reasonable times, and after reasonable notice. The university's right of access to the data shall continue regardless of the location of the responsible investigator. Information or data that would violate the confidentiality of sources or subjects involved in the research should not be disclosed. Extramural sponsors providing support for research at ISU may also have the right to review the data and records resulting from that extramural support. Co-investigators and trainees who are an integral part of a research project have the right to review all records and data which are part of that project.

K.4 Other Regulations related to Privacy, Confidentiality, and Consent

In addition to 45 CFR 46 and FDA regulations under 21 CFR 50, other federal regulations may apply to research involving human subjects.

K.4.1 Privacy Rule under the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

The Privacy Rule, a Federal regulation under the Health Insurance Portability and Accountability Act (HIPAA) of 1996, regulates the way covered entities handle individually identifiable health information known as protected health information (PHI). The Privacy Rule itself applies only to covered entities, not to research itself; however, the Privacy Rule may affect researchers because it establishes the conditions under which covered entities can use or disclose PHI for research. ISU is a hybrid entity, which means that some units are covered under HIPAA, while other units are not. The Privacy Rule does not directly regulate researchers who are engaged in research within units that are not part of the covered entities, even though they may gather, generate, access, and share

personal health information. The Privacy Rule is in 45 CFR Part 160 and Subparts A and E of Part 164. Appendix 4 contains more detailed information related to the Privacy Rule. PIs planning to engage in physical or medical health related research that is covered under the Privacy Rule are advised to begin consultation with the covered entity early in the research design process.

K.4.2 Family Education Rights and Privacy Act

The Family Education Rights and Privacy Act (FERPA) is a federal law (20 U.S.C. § 1232g; 34 CFR Part 99 "EDGAR" regulations) that applies to educational agencies and institutions that receive federal funds under any program administered by the Secretary of Education. FERPA gives parents certain rights with respect to their children's education records. These rights transfer to the student when they reach age 18 or attends a postsecondary school. Students to whom the rights have been transferred are "eligible students."

Generally, schools must have written permission from the parent or eligible student before releasing any identifiable information from a student's education record. The consent must specify the records that may be disclosed, state the purpose of the disclosure, and identify the party to whom the disclosure may be made. FERPA does, however, allow schools to disclose records to organization(s) conducting studies for, or on behalf of the school, in order to develop, validate, or administer predictive tests; administer student aid programs; or improve instruction. Additionally, schools may disclose, without consent, "directory" information, unless specifically directed by parents or eligible students not to disclose directory information about them. PIs are encouraged to consult with the school early in the research design process regarding the need to obtain consent for educational records.

K.4.3 Protection of Pupil Rights Amendment

The Protection of Pupil Rights Amendment (PPRA) is a federal regulation (20 U.S.C. § 1232g; 34 CFR Part 99) that was amended by Congress in 2001 by the No Child Left Behind Act regulates survey research in schools. Schools and contractors must obtain prior written parental consent before minor students are required to participate in any U.S. Department of Education funded survey, analysis, or evaluation that reveals information concerning the following: political affiliations or beliefs of the student or the student's parent; mental and psychological problems of the student or the student's family; sex behavior or attitudes; illegal, anti-social, self-incriminating, or demeaning behavior; critical appraisals of other individuals with whom respondents have close family relationships; legally recognized privileged or analogous relationships, such as those of lawyers, physicians, and ministers; religious practices, affiliations, or beliefs of the student or student's parent; or income (other than that required by law to determine eligibility for participation in a program or for receiving financial assistance under such program). Additionally, local educational agencies or institutions that receive funds under any program administered by the U.S. Department of Education are required to develop and adopt policies concerning parents' rights to inspect, upon request, any survey created by a third party before the survey is administered or distributed by a school to students and provide parents the opportunity to ask that their child not participate. PIs are encouraged to consult with the school early in the research design process regarding how PPRA may impact the research protocol.

L. INTERNET RESEARCH

Non-exempt research using the Internet has unique characteristics that are not directly addressed by the Federal regulations. Currently, the Internet is used primarily for the following research activities: 1) recruitment of subjects 2) survey administration, and 3) interviewing. Most human subjects' protection issues that arise in conducting research activities on the Internet concern privacy and consent. For a thorough discussion of the pertinent issues, refer to the Considerations and Recommendations Concerning Internet Research and Human Research Regulations.

The ability to consent is difficult to ascertain over the Internet. Generally, this ability is related to age, but may be relevant to other vulnerable populations (e.g., divisionally impaired, incarcerated). Also, email-based activities are far less secure than website- based activities. Software exists to enhance the privacy of both types of activities. ISU strongly recommends that researchers utilized an ISU sponsored survey platform with a vendor that specializes in Internet-based research to minimize risks in these areas. If researchers do not plan to collect identifying information, the PI is required to take steps to ensure that the platform they are using does not collect identifying information.

Internet-based studies may not include minors as subjects unless the IRB waives written parental permission and informed consent.

Whether the purpose is recruitment, survey administration, or some other purpose, Internet-based materials must include the following items, to the extent applicable. These items are to be included **in addition to** all information that is normally required for informed consent:

- email addresses of the investigator and IRB (unless otherwise stated by the Board)
- no claim about the superiority, safety, or effectiveness of procedures, interventions, devices, or any other materials used in research;
- a description of the process for completing the on-line research activity
- information on subsequent contacts that will be made if the individual agrees to participate
- no promise of anonymity
- information regarding procedures for protection of information that the subject provides over the Internet
- a statement that there will be no future email contacts or an opt-out message that permits individuals to have their names removed from any future mailings. If future contacts are planned, the information must state the number and frequency of such contacts.
- instructions to delete the email message that originated the contact

After reading information about the study, the individual must be required click a button to indicate their wish to participate or to leave the site and opt out of participation. After clicking the button, the subject will be taken to the study task. If the individual opts out, clicking the button will exit data collection.

Generally, Internet-based surveys do not require written documentation of a consent signature. If the IRB does require such documentation, the following additional procedures must be used:

- The “agree to participate” button must contain a message, or there must be a separate statement right above the button, that indicates that clicking the button means the subject has read the statement, printed a copy for their files, and agrees to participate in the study or be considered for recruitment for the study and accepts that personal information will be electronically supplied to the researcher to document their participation (such as name, e-mail name, and date).
- Unless there is a waiver to the consent or signature procedures, there must be a mechanism by which information is returned to the researcher that identifies the person who is participating.

The following apply to all types of study materials:

- Individuals must be able to easily print a readable copy of information about the study and the informed consent documentation (unless consent procedures are waived) for their own records. Copies of the consent form can be provided electronically or by printed copy
- The IRB must be able to access the live on-line survey before approval or exempt determination will be given.

M. HUMAN SUBJECTS PROTECTION IN FIELD RESEARCH

Field research typically involves observation of and interaction with individuals and groups in their own environment, often over long periods of time. It also includes other types of generally qualitative activities that fall under the definition of research, such as interview conducted for historical or biographical research and archival research on identifiable living individuals. Interviews by journalists conducted solely for the purpose of writing an article in a newspaper, magazine, or other media outlet are not considered research and do not require IRB review.

It may not be possible to specify in an informed consent statement the detailed description of the research protocol, as the research itself may involve interactions between the researcher and subjects that evolve over time. Likewise, differences in language, culture, or the nature of the subjects or topic may preclude the use of a written informed consent document. If appropriate justification is given, the IRB may waive the requirement for some or all of the informed consent requirements or the requirement to obtain signed informed consent in certain situations; 45 CFR 46.116(c) and (d) describes the circumstances in which waiver is possible (also see Appendix 3 of this policy for more information). The investigator should request such a waiver if they determine that it is appropriate. The IRB will make the final determination. In addition, the sensitive nature of some field research may make it advisable for the investigator to consider obtaining a Certificate of Confidentiality. Investigators conducting field research should consider guidelines developed by a relevant professional association, such as the American Anthropological Association, the American Historical Association, or the American Sociological Association, when designing their protocols.

N. OTHER STUDIES INVOLVING HUMAN SUBJECTS

This section sets out policy for conducting other types of studies that include human subjects, but do not meet the Federal definition of research.

N.1 Student Projects

Generally both graduate and undergraduate student research involving human subjects is either in the form of class projects or independent directed research projects. The type of review required is determined by whether the research projects are intended to contribute to generalizable knowledge (please contact the IRB chair or vice chair for determination assistance). Student projects involving human subjects that fall into the following categories **always** require IRB review and approval or exemption certification, as described in previous sections of this policy.

- Theses and dissertations
- Projects undertaken with the intent of presenting findings at a conference (including ISU or other university-affiliated undergraduate or graduate research presentation venues)
- Projects undertaken with the intent of publication, including publication on the Internet.

Many courses include projects that are designed to train students in research methods such as anonymous surveys, oral histories, field work in cultural anthropology, clinical interns practicing diagnosis, and program evaluations conducted in connection with a student internship. Many independent directed research projects may have these same goals. While these projects do not normally require IRB review, they are subject to faculty oversight.

Class projects and independent directed research projects not designed to contribute to generalizable knowledge do not require IRB review unless the proposed research places the subjects at more than minimal risk, usually evidenced by one or more of the following:

- Subjects are members of a vulnerable population, as per ISU Policy, federal regulations, or federal guidance.
- The study asks identifiable subjects about illegal activities (e.g., underage drinking), which may place the data at risk of subpoena.
- The study places identifiable subjects at risk of a breach of confidentiality that may lead to criminal or civil liability, or damage the subject's financial standing, employability, or reputation (45 CFR 46.109(b)(3)).
- The study places subjects at more than minimal risk due to psychologically sensitive subject matter (e.g., interviews covering traumatic events).

N.1.1 Sponsor Responsibilities in Student Projects

All student projects must have an ISU faculty or EAP staff sponsor. For class projects, this is usually the instructor. The instructor should supervise the student researcher sufficiently to assure the protection of human research subjects in accordance with ethical standards of the relevant discipline.
All faculty members or EAP staff who supervise any type of student project using human subjects must be trained in accordance with ISU policy.

The instructor is responsible for determining whether the proposed study is designed to contribute to generalizable knowledge and is subject to IRB review. If so, the instructor (i.e., faculty sponsor) must assist the student in preparing the application for review.

Even though IRB review may not be required for most student projects, these projects must communicate applicable elements of informed consent (e.g., institutional affiliation of researcher, risk, benefit, voluntary participation, permission to withdraw, etc.) and include appropriate anonymity and confidentiality protections. Before conducting research, students must be taught about the ethics of conducting research with human subjects. Instruction should, at a minimum, include information on the purpose of the IRB, the informed consent process, and the principles set forth in the Belmont Report. The instructor may require the student to complete a designated training program. The IRB advocates that departments use this training program in research methods courses as the mechanism to ensure that students have been properly instructed in the protection of human research subjects.

The instructor must investigate any problem reported by the student. If any harm to a subject has occurred, the instructor must report in writing to the IRB immediately and have the student cease research activities until a decision is made regarding continuation of the project.

N.1.2 Student Researcher Responsibilities

Students must conduct only the activities approved by the instructor. Activities must be conducted in accordance with the principles set forth in the Belmont Report and ISU Policy.
Students must report to the instructor any problems that arise regarding human subjects.

N.2 Institutional Research

Data collected or studies conducted for purposes of providing information to the university, any unit within the university, or any other organization (e.g., accrediting agency), with the purpose of addressing issues deemed important to university operations is considered to be institutional research. Studies of this nature do not require IRB review. If information collected is intended for further dissemination, publication (including Internet), or involves more than minimal risk, it requires IRB review.

When IRB review is not required, institutional research projects or other activities must still communicate applicable elements of informed consent (e.g., purpose, risk, benefit, voluntary participation, permission to withdraw) and include appropriate anonymity and confidentiality protections.

N.3 Other Projects

The primary types of projects included in this category are program evaluation, policy analysis, or quality assurance studies conducted for the purpose of providing information only to the organization studied. Such studies do not require IRB review if they involve no more than minimal risk as defined in Federal regulations and ISU policy and do not involve vulnerable populations.

Any such project conducted with the intent of further dissemination of results meets the definition of research according to federal and ISU policy and requires IRB review.

When IRB review is not required, such projects must still communicate applicable elements of informed consent and include appropriate anonymity or confidentiality protections.

N.4 Publicly Available Data

Many private organizations and public agencies make individual level data available to the public. Such files fall outside the federal regulations for the protection of human subjects, once they have been classified as public use data files. Not all publicly available data, however, has been classified as public use.

To classify files as public use, producers and suppliers of such files are responsible for having the data reviewed by the appropriate IRB before making them available to the public. Information to this effect should be indicated on the documentation supplied with the file.

PIs do not need to obtain IRB approval to use public use data files nor do they need to seek IRB review of the exemption status of the data. Where applicable, such information has already been reviewed for the protection of human subjects and the files produced have been certified not to violate confidentiality.

If an ISU PI plans to obtain individually identifiable data (from the sponsor of the public use data file or any other source) and merge with the public use data file, the ISU investigator must seek IRB approval.

If the public use status cannot be ascertained from the documentation supplied with the file, the ISU PI must contact the supplier to ascertain the public use status of the data. If this status cannot be ascertained and provided to the PI in writing or if the data are not classifiable as "public use," then the ISU PI must submit an application for IRB review. For example, this situation may occur when an investigator receives permission from a PI at another university to use data produced from a research project that is ongoing.

In addition to data files, any published hard copy or electronic documents (including web pages) available to the public that contain individual data (whether identifiable or not identifiable) fall outside federal regulations for the protection of human subjects. PIs do not need to obtain IRB approval to use such information nor do they need to seek IRB review of the exemption status of the data.

O. TRAINING

O.1 Who Must Be Trained?

ISU's assurance with the OHRP requires certification for all IRB members and alternates, PIs, and co-PIs who conduct research involving human subjects. This assurance also requires that ISU provide continuing education on research with human subjects.

The training requirements discussed herein cover all funded and non-funded projects that include human subjects. This policy covers all proposed and ongoing projects submitted to the IRB for approval, regardless of the level of review required (i.e., full, expedited, exempt).

If any new investigator is added after the submission of the initial application or a continuation request, the PI must submit these names via IRBNet. These investigators must be trained before working with human research subjects. The IRB strongly recommends that the PI and co-PI provide the opportunity for all staff working on the research project to successfully complete the training.

O.2 When Training Must Occur

Training of all PIs and co-PIs must be completed before the project or renewal is approved.
In addition, funding agencies may require completion of training before funds are approved or released, and may have training requirements that exceed ISU's. The PI is responsible for adhering to both ISU's and the funding agency's training policies.

Initial certification is valid for three (3) years. All investigators trained must renew certification every three years while working with human subjects. All IRB members and alternates must complete the certification when first appointed to the IRB; furthermore, they must participate in continuing education through IRB meeting activities. No less than 30 days before the expiration of certification, the individuals requiring recertification will be notified of the requirements for re-certification. Recertification of all investigators must occur before the IRB can renew approval of a project.

O.3 Training Procedures and Certification

Follow the training procedures are described in Appendix 5.

P. STUDENTS AS RESEARCH SUBJECTS

Students are often used as subjects in research studies, both by ISU student, faculty, and staff researchers as well as researchers from other universities and organizations. Because of their unique position, ISU policy addresses several issues pertaining to the use of students in research projects.

P.1 Types of Activities Covered by this Section

Some course work involves research-type activities that serve an entirely pedagogical purpose. For example, professors may have students administer surveys or psychological instruments to each other in class so that they can practice interviewing techniques.

These activities are not considered research, as defined by Federal regulations or this policy, do not require IRB review, and are not covered by this section. Projects in which students include other students from outside of their classroom in studies that are not designed for use beyond a course are not considered research as defined by federal regulations or this policy (e.g., administering a brief survey to students in the dining hall regarding food service). Although they are not covered in this section, these studies should follow guidance as set forth in Section N of this policy.

Research involving normal educational practices typically falls under an exempt review category (examples on Exempt Form) under 45 CFR 46.101(b)(1) and must be submitted to the IRB for exemption certification. Informed consent procedures must be followed, though. In many such cases, students cannot opt out of participation in the intervention, because the intervention may be the pedagogical techniques routinely used in the class. In such studies, the instructor should provide information on the research at the beginning of the course. This information should offer the student the option to refuse to have their information (e.g., grades) included in the study. If the study is conducted at another school (e.g., student teaching assignment), informed consent must be obtained in accordance with the rules of that school, as well. In these studies, the informed

consent must include a contact person to address questions regarding the study who it not the instructor or graduate assistant assigned to the course.

Research that is exempt under 45 CFR 46.101(b)(2) and (3) and all non-exempt research must follow the recruitment and protection policies set forth in this section.

P.2 Recruitment of Students for Research Studies

This section discusses the following distinct groups of students: 1) a PI's current students, 2) other ISU students, and 3) students at other schools who are participants in ISU studies.

ISU policy regarding protection of human subjects must be followed with all students, whether they are ISU students or students at another school. Additional protections are required when the potential research subjects are a PI's current students. A PI's current students include those at ISU or at any other location(s) where the person teaches under the auspices of ISU (e.g., student teaching, prison-based courses).

ISU does not normally allow students to participate in a research study conducted by a PI from whom they are currently taking classes except under the exemption categories (45 CFR 46.101(b)(1)). If the nature of the study or other circumstances makes it impossible to conduct the study without using one's own students, the IRB may consider exceptions on an individual basis.

The preferred method is to have data collected by an independent third party (e.g., colleague in own or other department), in such a way that the instructor does not know the identity of the participants and does not have access to identifiable data until final course grades have been assigned and entered. If data are collected in the classroom, the instructor shall not be present. The third party cannot be a graduate assistant assigned to the course, but may be a graduate assistant who works on the study. This method should be used wherever feasible, even if the information from the students is anonymous (e.g., anonymous self-administered survey).

If a third party is not available, data from an instructor's current students may be used only if written consent is obtained from the student after final course grades are assigned and entered. This written consent must include language that indicates that participation is voluntary.

ISU discourages situations that allow a student to enter the faculty researcher's class while that student is participating in the faculty member's research project. While this may not be avoidable (e.g., due to scheduling of courses in a student's major), special care must be taken to follow the rules discussed above.

P.3 Awarding Credit for Participation in Research Studies

Researchers may award course credit or extra credit for participation in research if and only if another opportunity to earn the same amount of credit is available to students who decline to participate. The amount of work required to receive the credit must be similar to that required for participation in the study. For example, if the study consists of completion of an approximately 30-minute survey, then the extra credit for non- participants should require a task that takes about the same length of time.

The informed consent process must explicitly state how much extra credit is to be awarded and at what point. Informed consent must indicate how or whether extra credit will be awarded if the student withdraws from the

study before completion. ISU generally favors awarding extra credit if a student withdraws, unless the withdrawal is immediate (e.g., before the intervention or experiment begins) or unless there is ample evidence of bad faith on the part of the student. If the student disputes awarding of credit in an approved study, they may appeal to the department chairperson, whose decision is final. If the department has a different policy regarding handling of disputes over the awarding of credit for research project participation, then the department's policy takes precedence.

Q. CHARGES FOR IRB REVIEW SERVICES

The number and complexity of human research protocols at Indiana State University have increased substantially in recent years. Each of these studies requires review and ongoing oversight by the Institutional Review Board (IRB), a process that is vital to the university's ability to conduct research. Effective July 1, 2006, the charge for initial IRB review of a single protocol will be $1000 for grant-funded projects not administered through the university. There will be no fee assessed for projects which are grant funded if the grant is administered by ISU. There will also be no fee for unfunded research conducted at the university. This will be a one-time upfront fee, with no additional charge for the continuing (annual) review of a protocol, or for the processing of protocol amendments.

R. MEDICAL DEVICES

This section sets out policy for the review of research studies involving human subjects utilizing medical devices, which must comply with FDA regulations for devices intended for human use [21 CFR 812 Investigational Device Exemption].

A medical device is defined as a diagnostic or therapeutic article that does not achieve any of its principal intended purposes through chemical action within or on the body. Such devices include diagnostic test kits, crutches, electrodes, pacemakers, arterial grafts, intraocular lenses, and orthopedic pins or other orthopedic equipment. Investigational Device Exemption (IDE) allows the investigational device to be used in a clinical trial in order to collect safety and effectiveness data required to support a Pre- market Approval application (PMA) or a Pre-market Notification (510(k)) submission to the FDA. It permits a device to be shipped lawfully for purposes of conducting investigations of that device. IDE regulation describes three types of device studies: significant risk (SR), non-significant risk (NR), and exempt studies. A medical device is subject to the requirements of the IDE regulations UNLESS exempt.

R.1 Exempt studies

Exempt studies, which are not subject to the requirements of the IDE regulations, include:

- Consumer preference testing, testing of a device modification, or testing of two
- (2) or more devices in commercial distribution if the testing does not collect safety or effectiveness data or put subjects at risk; (see 21 CFR 812.2(c)(4))
- Studies of an already cleared medical device in which the device is used or investigated in accordance with the indications in the cleared labeling; (see 21 CFR 812(c)(1)(2))

- Diagnostic device studies (e.g., in vitro diagnostic studies) under certain circumstances. [21 CFR 812(c)(3)] IDE exempt studies that are being conducted to collect data to support either a clinical investigation or a marketing application must comply with the requirement for IRB review and should comply with the requirements for informed consent.

R.2 Determination of Significant Risk or Non-significant Risk Status

Device investigations are scheduled for review at a convened meeting of the IRB. As part of its review, the IRB must categorize the investigation as either "significant risk" (SR) or "non-significant risk" (NSR). The organization funding the research or the researcher/inventor makes the initial risk assessment, however, the IRB will make a final determination regarding the appropriate SR/NSR category during a convened meeting.

Non-significant Risk Device: An investigational medical device that does not present significant risk to the patient.

Significant Risk Device: An investigational medical device that presents a potential for serious risk to the health, safety, or welfare of the subject. Such a device is:

- Intended for use as an implant and presents a potential for serious risk to the health, safety, or welfare of the subject; or
- Purported or represented to be of use in supporting or sustaining human life and presents a potential for serious risk to the health, safety, or welfare of the subject; or
- Intended for a use that is of substantial importance in diagnosing, curing, mitigating, or treating disease, or otherwise preventing impairment of human health, and presents a potential for serious risk to the health, safety, or welfare of the subject; or
- Otherwise presents a potential for serious risk to the health, safety, or welfare of a subject.

To aid in the determination of the risk status of the device, the IRB shall review information such as:

- Reports of prior investigations conducted with the device
- The protocol
- Description of the participant selection criteria
- Monitoring procedures.

The sponsor or researcher/inventor must provide the IRB with a risk assessment and the rationale used in making its risk determination. The sponsor should also inform the IRB whether other IRBs have reviewed the proposed study and what determination was made. The IRB will base their determination on the proposed use of the device in the investigation, and not on the device alone. If the proposed use of the device involves a procedure, e.g., a surgical procedure, the IRB will consider the potential harm that could be caused by the procedure as well as the device.

If the IRB concurs with the sponsor or researcher/inventor that the research is a NSR device investigation, the investigation may proceed when fully approved by the IRB and does not require an IDE application approved by the FDA. The IRB will record the NSR determination within the minutes of the full board meeting.

When the IRB makes an NSR determination and the risk to the subjects is determined to be minimal in accordance with 21 CFR 56.102(i), the IRB may vote to allow continuing review to be conducted using the expedited review procedure, as long as the research poses no more than minimal risk to subjects and no additional risks have been identified.

If the IRB determines that the research is a SR device investigation, the study cannot proceed and the sponsor must submit an IDE application to the FDA. The sponsor must notify the FDA that the IRB has considered the device SR. The study may proceed as a SR study following FDA approval of an IDE application and IRB approval. The FDA has the ultimate decision in determining if a device protocol is SR or NSR. The IRB requires documentation that the IDE is in effect before the research can be fully approved.

R.3 General Review

Following determination of risk status by the convened IRB, the research will be reviewed and considered for approval in accordance with IRB Policy. The IRB may approve or disapprove the proposed research based on local context and its responsibilities to protect human subjects in research even when the FDA has granted approval of the device.

R.4 Control of Devices

When an investigator is conducting an investigational device study, the IRB requires the investigator to have a written plan for control of investigational devices including ordering, handling, storage, dispensing and return, if applicable. The investigator is responsible for the control of investigational devices in accordance with institutional policy and FDA regulations.

- The investigator shall maintain accurate, complete, and current records of receipt, use, and disposition of the device which relate to:
  - Type and quantity of the device, dates of receipt, and the batch number or code mark
  - Names of all persons who received, used, or disposed of each device
  - Why and how many units of the device have been returned to the sponsor, repaired, or otherwise disposed of.

R.5 Humanitarian Use Devices (HUD)

HUDs with approved Humanitarian Device Exemptions (HDEs) may be used for the FDA approved indication only with approval of the IRB. The IRB may vote to allow continuing review to be conducted using the expedited review procedure, as long as the use of the HUD is used within the scope of its approved labeling. The FDA does not consider the use of a HUD within its approved labeling to be research. When HUDs are being evaluated for safety and effectiveness beyond the scope of the FDA approved HDE indication, they are subject to the requirements of device investigations as described in this Policy.

R.6 Custom Devices

Custom devices made in a specific form for a given patient on the order of a physician or dentist as part of their professional practice are not subject to the requirements for device investigations unless the devices are being evaluated for safety and effectiveness. In such cases, custom devices are subject to the requirements of device investigations as described in this Policy.

R.7 Non-FDA Approved Devices Used as a Tool to Study Human Physiology

Non-FDA approved devices used in research to study human physiology are not subject to the 812 IDE regulations, but must meet the criteria for non-significant risk devices to be used in human subjects.

R.8 Non-Hospital Inventory FDA-Approved Medical Devices Used for Monitoring or Data Collection

Commercially available FDA-approved medical devices used in research according to the FDA approved labeling are not subject to the 812 IDE regulations, but must meet the same hospital safety standards as medical devices being used for patient care.

Appendix 1 - Lists of Checklists and Instructions for Submissions and Forms

The following Checklists and Instructions for Submitting Materials for Review by the University Institutional Review Board are available in IRBnet.org.

- New Application- Checklist and Instructions
- Modification Request- Checklist and Instructions
- Continuation Request- Checklist and Instructions
- PI Report of Problems Involving Risk, Adverse Effects, or Non-Compliance - Instructions and Checklist
- Completion of Research Activities – Instructions

Appendix 2 – Reviewer Checklist

Minimal regulatory requirements for IRB review, discussion, and documentation in the meeting minutes from IRB Protocol Review Guidelines (http://ohsr.od.nih.gov/info/checklist_IRB_protocol.html)	
Regulatory review requirement	**Suggested questions for IRB discussion**
1. The proposed research design is scientifically sound & will not unnecessarily expose subjects to risk.	Is the hypothesis clear? Is it clearly stated? Is the study design appropriate to test the hypothesis? Will the research contribute to generalizable knowledge and is it worth exposing subjects to risk?
2. Risks to subjects are **reasonable** in relation to anticipated benefits, if any, to subjects, **and** the importance of knowledge that may reasonably be expected to result.	What does the IRB consider the level of risk to be? (See risk assessment guide on back of form.) What does the PI consider the level of risk/discomfort/ inconvenience to be? Is there prospect of direct benefit to subjects? (See benefit assessment guide on back of form.)
3. Subject selection is equitable.	Who is to be enrolled? Men? Women? Ethnic minorities? Children (rationale for inclusion/exclusion addressed)? Seriously-ill persons? Healthy volunteers? Are these subjects appropriate for the protocol?
4. Additional safeguards required for subjects likely to be vulnerable to coercion or undue influence.	(a) Are appropriate protections in place for vulnerable subjects, e.g., pregnant women, fetuses, socially- or economically-disadvantaged, decisional-impaired?
5. Informed consent is obtained from research subjects or their legally authorized representative(s).	Does the informed consent document include the eight required elements? Is the consent document understandable to subjects? Who will obtain informed consent (PI, nurse, other?) & in what setting? If appropriate, is there a children's assent? Is the IRB requested to waive or alter any informed consent requirement?
6. Subject safety is maximized.	Does the research design minimize risks to subjects? Would use of a data & safety monitoring board or other research oversight process enhance subject safety?
7. Subject privacy & confidentiality are maximized.	Will personally-identifiable research data be protected to the extent possible from access or use? Are any special privacy & confidentiality issues properly addressed, e.g., use of genetic information?

Additional considerations	
1. Ionizing radiation.	If ionizing radiation is used in this protocol is it medically indicated or for research use only?
2. Collaborative research.	Is this domestic/international collaborative research? If so, are SPAs or other assurances required for the sites involved?
3. FDA-regulated research	Is an investigational new drug (IND) or investigational device exemption (IDE) involved in this protocol?
4. Other	

Risk/Benefit Assessment

Risk

Regulatory definition of minimal risk: Minimal risk means that the probability and magnitude of harm or discomfort anticipated in the research are not greater in and of themselves than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests (45 CFR 46.102(h)(i)).

Check appropriate risk categories.

The research involves no more than minimal risk to subjects.

- The research involves more than minimal risk to subjects.
- The risk(s) represents a minor increase over minimal risk, **or**
- The risk(s) represents more than a minor increase over minimal risk.

Benefit

Definition: A research benefit is considered to be something of health-related, psychosocial, or other value to an individual research subject, or something that will contribute to the acquisition of generalizable knowledge. Money or other compensation for participation in research is **not** considered to be a benefit, but rather compensation for research-related inconveniences.

Check appropriate benefit category:

- The research involves no prospect of direct benefit to individual subjects, but is likely to yield generalizable knowledge about the subject's disorder or condition.
- The research involves the prospect of direct benefit to individual subjects.

Appendix 3 - Informed Consent

Informed Consent Checklist

Informed consent/assent forms should be written in second person (e.g., you are being asked to participate…).

Basic elements to include:

A statement that the study involves research
An explanation of the purposes of the research
A concise and focused presentation of the key information that is most likely to assist a prospective subject or legally authorized representative in understanding the reasons why one might or might not want to participate in the research.
The expected duration of the subject's participation
A description of the procedures to be followed
Identification of any procedures which are experimental
A description of any reasonably foreseeable risks or discomforts to the subject, an estimate of their likelihood, and a description of what steps will be taken to prevent or minimize them
A description of any benefits to the subject or to others which may reasonably be expected from the research. Monetary compensation is not a benefit. If compensation is to be provided to research subjects or healthy volunteers, the amount should be stated in the consent document
A disclosure of appropriate alternative procedures or courses of treatment, if any, that might be advantageous to the subject
A statement describing the extent, if any, to which confidentiality of records identifying the subject will be maintained. Include a description of whom may have access to research records
For research involving more than minimal risk, an explanation as to whether any compensation, and an explanation as to whether any medical treatments are available, if injury occurs and, if so, what they consist of, or where further information may be obtained
An explanation of whom to contact for answers to pertinent questions about the research and research subjects' rights, and whom to contact in the event of a research-related injury to the subject
A statement that participation is voluntary, refusal to participate will involve no penalty or loss of benefits to which the subject is otherwise entitled, and the subject may discontinue participation at any time without penalty or loss of benefits, to which the subject is otherwise entitled
One of the following statements about any research that involves the collection of identifiable private information or identifiable bio specimens: A statement that identifiers might be removed from the identifiable private information or identifiable bio specimens and that, after such removal, the information or bio specimens could be used for future research studies or distributed to another investigator for future research studies without additional informed consent from the subject or the legally authorized representative, if this might be a possibility; or A statement that the subject's information or bio specimens collected as part of the research, even if identifiers are removed, will not be used or distributed for future research studies.

Additional elements of informed consent.

If it is appropriate to the research, it is also required that one or more of the following elements of information be provided to each subject or the legally authorized representative:

A statement that the particular treatment or procedure may involve risks to the subject (or to the embryo or fetus, if the subject is or may become pregnant) that are currently unforeseeable;
Anticipated circumstances under which the subject's participation may be terminated by the investigator without regard to the subject's or the legally authorized representative's consent;
Any additional costs to the subject that may result from participation in the research;
The consequences of a subject's decision to withdraw from the research and procedures for orderly termination of participation by the subject;
A statement that significant new findings developed during the course of the research that may relate to the subject's willingness to continue participation will be provided to the subject;
The approximate number of subjects involved in the study;
A statement that the subject's bio specimens (even if identifiers are removed) may be used for commercial profit and whether the subject will or will not share in this commercial profit;
A statement regarding whether clinically relevant research results, including individual research results, will be disclosed to subjects, and if so, under what conditions; and
For research involving bio specimens, whether the research will (if known) or might include whole genome sequencing (*i.e.,* sequencing of a human germline or somatic specimen with the intent to generate the genome or exome sequence of that specimen).

Conditions for Waiver of Some or All Informed Consent Requirements

Requirements for waiver and alteration. In order for an IRB to waive or alter consent as described in this subsection, the IRB must find and document that:

The research involves no more than minimal risk to the subjects;

i. The research could not practicably be carried out without the requested waiver or alteration;
ii. If the research involves using identifiable private information or identifiable bio specimens, the research could not practicably be carried out without using such information or bio specimens in an identifiable format;
iii. The waiver or alteration will not adversely affect the rights and welfare of the subjects; and
iv. Whenever appropriate, the subjects or legally authorized representatives will be provided with additional pertinent information after participation.

Conditions for Waiver of Requirement to Obtain Signed Informed Consent

An IRB may waive the requirement for the investigator to obtain a signed informed consent form for some or all subjects if it finds any of the following:

i. That the only record linking the subject and the research would be the informed consent form and the principal risk would be potential harm resulting from a breach of confidentiality. Each

subject (or legally authorized representative) will be asked whether the subject wants documentation linking the subject with the research, and the subject's wishes will govern;

ii. That the research presents no more than minimal risk of harm to subjects and involves no procedures for which written consent is normally required outside of the research context; or

iii. If the subjects or legally authorized representatives are members of a distinct cultural group or community in which signing forms is not the norm, that the research presents no more than minimal risk of harm to subjects and provided there is an appropriate alternative mechanism for documenting that informed consent was obtained.

iv. (2) In cases in which the documentation requirement is waived, the IRB may require the investigator to provide subjects or legally authorized representatives with a written statement regarding the research.

v. (Approved by the Office of Management and Budget under Control Number 0990–0260)

Appendix 4 - HIPAA Information

4.a Definitions used in the Privacy Rule

(1) Covered Entity - A health plan, a health care clearinghouse, or a health care provider who transmits health information in electronic form in connection with a transaction for which HHS has adopted a standard.

(2) Health Care Provider - A provider of services (as defined in section 1861(u) of the Act, 42 U.S.C. 1395x(u)), a provider of medical or health services (as defined in section 1861(s) of the Act, 42 U.S.C. 1395x(s)), and any other person or organization who furnishes, bills, or is paid for health care in the normal course of business.

(3) Health Care - Care, services, or supplies related to the health of an individual, including (1) preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, service, assessment, or procedure with respect to the physical or mental condition, or functional status, of an individual that affects the structure or function of the body; and (2) sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription.

(4) Protected Health Information - PHI is individually identifiable health information transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. PHI excludes education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. 1232g, records described at 20 U.S.C. 1232g(a)(4)(B)(iv), and employment records held by a covered entity in its role as employer.

(5) Research (as defined under the Privacy Rule) - A systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge. This includes the development of research repositories and databases for research.

(6) Authorization - An individual's written permission to allow a covered entity to use or disclose specified PHI for a particular purpose. Except as otherwise permitted by the Rule, a covered entity may not use or disclose PHI for research purposes without a valid Authorization.

(7) Data Use Agreement- An agreement into which the covered entity enters with the intended recipient of a limited data set that establishes the ways in which the information in the limited data set may be used and how it will be protected.

(8) Health Information - Any information, whether oral or recorded in any form or medium, that (1) is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual.

(9) Individually Identifiable Health Information - Information that is a subset of health information, including demographic information collected from an individual, and (1) is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and (a) that identifies the individual; or (b) with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

(10) Limited Data Set - Refers to PHI that excludes 16 categories of direct identifiers and may be used or disclosed, for purposes of research, public health, or health care operations, without obtaining either an

individual's Authorization or a waiver or an alteration of Authorization for its use and disclosure, with a data use agreement.

(11) Waiver or Alteration of Authorization - The documentation that the covered entity obtains from a researcher or an IRB or a Privacy Board that states that the IRB or Privacy Board has waived or altered the Privacy Rule's requirement that an individual must authorize a covered entity to use or disclose the individual's PHI for research purposes.

4.b Authorizations

The Privacy Rule allows covered entities to use and disclose PHI for research if explicitly authorized to do so by the subject in accordance with the Privacy Rule. The Authorization for use of PHI for research may be combined with informed consent for participation or the Authorization may be a stand-alone HIPAA authorization document. The Authorization and informed consent form must be kept for 6 years after the conclusion of the study.

4.b.1 Authorization Document

The HIPAA authorization document (either a stand-alone document or part of an informed consent form) must contain the following specific core elements and required statements:

Authorization Core Elements:

- A description of the PHI to be used or disclosed, identifying the information in a specific and meaningful manner.
- The names or other specific identification of the person or persons (or class of persons) authorized to make the requested use or disclosure.
- The names or other specific identification of the person or persons (or class of persons) to whom the covered entity may make the requested use or disclosure.
- A description of each purpose of the requested use or disclosure.
- Authorization expiration date or expiration event that relates to the individual or to the purpose of the use or disclosure ("end of the research study" or "none" are permissible for research, including for the creation and maintenance of a research database or repository).
- Signature of the individual and date. If the individual's legally authorized representative signs the Authorization, a description of the representative's authority to act for the individual must also be provided.

Authorization Required Statements:

- A statement of the individual's right to revoke their Authorization and how to do so, and, if applicable, the exceptions to the right to revoke their Authorization or reference to the corresponding section of the covered entity's notice of privacy practices.
- Whether treatment, payment, enrollment, or eligibility of benefits can be conditioned on Authorization, including research-related treatment and consequences of refusing to sign the Authorization, if applicable.
- A statement of the potential risk that PHI will be re-disclosed by the recipient. This may be a general statement that the Privacy Rule may no longer protect health information disclosed to the recipient.

4.b.2 Waiver or Alteration of Authorization

Waiver or Alteration of Authorization, in whole or in part, needs to satisfy the following criteria:

- The use or disclosure of the PHI involves no more than minimal risk to the privacy of individuals based on, at least, the presence of the following elements:
- An adequate plan to protect health information identifiers from improper use and disclosure.
- An adequate plan to destroy identifiers at the earliest opportunity consistent with conduct of the research (absent a health or research justification for retaining them or a legal requirement to do so).
- Adequate written assurances that the PHI will not be reused or disclosed to (shared with) any other person or entity, except as required by law, for authorized oversight of the research study, or for other research for which the use or disclosure of the PHI would be permitted under the Privacy Rule.
- The research could not practicably be conducted without the waiver or alteration.
- The research could not practicably be conducted without access to and use of the PHI.

4.c Exceptions

The Privacy Rule also allows covered entities to use and disclose PHI without Authorization for certain types of research activities, including de-identified PHI; when the covered entity and researcher enter into a data use agreement for sharing a limited data set; and documentation that an IRB or Privacy Board has waived the requirement for Authorization or allowed an alteration of Authorization. Refer to Appendix 4 for more information on identifiers, data use agreement, and Authorization waivers or alteration.
Additionally, covered entities may use or disclose PHI to a researcher without an individual's Authorization, a waiver or alteration of authorization, or a data use agreement, when the researcher's request is solely to review PHI necessary to prepare a research protocol, the PHI will not be removed from the covered entity in the course of review, and the PHI is necessary for the research.

The covered entity may also use or disclose PHI of the deceased for research purposes without obtaining Authorizations from personal representatives or next of kin, a waiver or an alteration of Authorization, or a data use agreement. The covered entity, however, must obtain the following from the researcher who is seeking access to decedents' PHI: (1) oral or written representations that the use and disclosure is sought for research on the PHI decedents, (2) oral or written representations that the PHI for which use or disclosure is sought is necessary for research purposes, and 3) documentation, at the request of the covered entity, of the death of the individuals whose PHI is sought by the researchers.

4.c.1 Limited Data Set

The following identifiers must be removed from health information if the data are to qualify as a limited data set:

Names. Postal address information, other than town or city, state, and ZIP Code. Telephone numbers. Fax numbers. Electronic mail addresses. Social security numbers. Medical record numbers. Health plan beneficiary numbers. Account numbers.	Certificate/license numbers Vehicle identifiers and serial numbers, including license plate numbers. Device identifiers and serial numbers. Web universal resource locators (URLs). Internet protocol (IP) address numbers. Biometric identifiers, including fingerprints and voiceprints. Full-face photographic images and any comparable images.

A data use agreement is the means by which covered entities obtain satisfactory assurances that the recipient of the limited data set will use or disclose the PHI in the data set only for specified purposes. Even if the person requesting a limited data set from a covered entity is an employee or otherwise a member of the covered entity's workforce, a written data use agreement meeting the Privacy Rule's requirements must be in place between the covered entity and the limited data set recipient.

The Privacy Rule requires a data use agreement to contain the following provisions:

- Specific permitted uses and disclosures of the limited data set by the recipient consistent with the purpose for which it was disclosed (a data use agreement cannot authorize the recipient to use or further disclose the information in a way that, if done by the covered entity, would violate the Privacy Rule).
- Identify who is permitted to use or receive the limited data set.
- Stipulations that the recipient will
- Not use or disclose the information other than permitted by the agreement or otherwise required by law.
- Use appropriate safeguards to prevent the use or disclosure of the information, except as provided for in the agreement, and require the recipient to report to the covered entity any uses or disclosures in violation of the agreement of which the recipient becomes aware.
- Hold any agent of the recipient (including subcontractors) to the standards, restrictions, and conditions stated in the data use agreement with respect to the information.
- Not identify the information or contact the individuals.

4.d Disclosure of PHI

Upon receiving a subject's request, a covered entity must account for disclosures of that individual's PHI made on or after the covered entity's compliance date, unless a particular disclosure or type of disclosure (e.g., under Authorization for the disclosure, part of a limited data set under a data use agreement, prior to the compliance date) is excluded from this accounting requirement in 45 CFR 164.528(a). The accounting of disclosures starts with the covered entity's compliance date and goes back 6 years from the date of the request, not including periods prior to the compliance date. Therefore, a covered entity must keep records of disclosures for 6 years. The Privacy Rule allows for three methods for accounting for research-related disclosures that are made without the individual's Authorization or other a limited

data set: (1) standard approach, (2) a multiple-disclosures approach, and (3) an alternative for disclosures involving 50 or more individuals. See 45 CFR 164.528 for more information.

4.e Existing Protocols

For research studies that began before the compliance date (April 14, 2003), a covered entity may use or disclose PHI that was created or received for research either before or after the compliance date, if the covered entity obtained any of the following prior to the compliance date: 1) an Authorization or other express legal permission from an individual to use or disclose PHI for research, 2) the informed consent of the individual to participate in the research, or 3) a waiver of informed consent by the IRB. If a waiver of informed consent was granted initially, but an informed consent is sought from the research subject after the compliance date, the covered entity must obtain the individual's Authorization as required by the Privacy Rule unless use or disclose is permitted without Authorization. Also, if informed consent was obtained after the compliance date, the covered entity must obtain the individual's Authorization to use or disclose PHI.

4.f HIPAA Defined Personal Identifiers

Names. All geographic subdivisions smaller than a state, including street address, city, county, precinct, ZIP Code, and their equivalent geographical codes, except for the initial three digits of a ZIP Code if, according to the current publicly available data from the Bureau of the Census: The geographic unit formed by combining all ZIP Codes with the same three initial digits contains more than 20,000 people. The initial three digits of a ZIP Code for all such geographic units containing 20,000 or fewer people are changed to 000. All elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older.	Telephone numbers. Facsimile numbers. Electronic mail addresses. Social security numbers. Medical record numbers. Health plan beneficiary numbers. Account numbers. Certificate/license numbers. Vehicle identifiers and serial numbers, including license plate numbers. Device identifiers and serial numbers. Web universal resource locators (URLs). Internet protocol (IP) address numbers. Biometric identifiers, including fingerprints and voiceprints. Full-face photographic images and any comparable images. Any other unique identifying number, characteristic, or code, unless otherwise permitted by the Privacy Rule for re-identification.

Appendix 5 - Training Procedures for Human Subjects Protection

On-line Program Required

Unless otherwise approved by the IRB administrator, all training and recertification must be completed using the online system described below. If an investigator has received training elsewhere, the PI must submit the investigator's certification to the IRB administrator, care of OSP, for assessment of that training.

The online program consists of a core set of modules and a continuing education set of modules. The core set is to be completed as the first certification and the continuing education modules serve as recertification. Initial certification and recertification are valid for three years. Should individuals allow certification to lapse, they will need to complete the core training.

Core (Initial) Training

The core set of modules has the following tracks: 1) biomedical research, and 2) social and behavioral research. IRB members and alternates, Principal Investigators, and co-PIs may select the track most appropriate to their research and role and complete the required modules for the chosen track. The required modules for each track are as follows:

REQUIRED MODULES FOR EACH TRACK

BIOMEDICAL RESEARCH TRACK		SOCIAL & BEHAVIORAL RESEARCH TRACK
• Basic Institutional Review Board (IRB) Regulations and Review Process • Informed Consent • Social and Behavioral Research (SBR) for Biomedical Researchers • Records-Based Research • Research and HIPAA Privacy Protections • History and Ethics of Human Subjects Research • Indiana State University • Belmont Report and Its Principles • Populations in Research Requiring Additional Considerations and/or Protections		• History and Ethical Principles – SBE • Defining Research with Human Subjects – SBE • The Federal Regulations – SBE • Assessing Risk – SBE • Informed Consent – SBE • Privacy and Confidentiality – SBE • Indiana State University • Belmont Report and Its Principles • Unanticipated Problems and Reporting Requirements in Social and Behavioral Research

Based on the substantive content of the project, IRB chairperson or designated member or IRB administrator will determine whether any additional training modules are required.

Each module requires a test. Reading material from the website may be printed to assist in preparation for the tests. A final, overall score of 70% or higher is required for certification. A test over any module may be retaken an unlimited number of times to improve the overall score. Initial certification requires

satisfactory completion of the "Basic Course", valid for a period of three (3) years. After this period, satisfactory completion of the "Refresher Course" is required.

Go to http://www.citiprogram.org to access the online training modules:

- Click on Register for the CITI course.
- Select Indiana State University from the "All Others" menu.
- Click submit.
- Complete requested information on user name and password screen
- Complete the demographics screen (optional)
- Select the track appropriate to your research activity.
- At Learners menu choose Basic Course (if training is for initial certification.)
- Begin by clicking on Introduction (on grade book page).

Continuing Education

The continuing education modules are to be used for recertification. This set of modules has only one track, however, different modules are required depending on the type of research in which one is engaged.

REQUIRED MODULES

BIOMEDICAL REFRESHER COURSE	SOCIAL BEHAVIORAL REFRESHER COURSE
• History and Ethical Principles • Regulations and Process • Informed Consent • SBR Methodologies in Biomedical Research • Records-Based Research • Genetics Research • Populations in Research Requiring Additional Considerations and/or Protections • Research Involving Prisoners • Research Involving Children • Research Involving Pregnant Women, Fetuses, and Neonates • FDA-Regulated Research • HIPAA and Human Subjects Research • Instructions • Conclusion • Conflicts of Interest in Research Involving Human Subjects	• History and Ethical Principles • Federal Regulations for Protecting Research Subjects • Informed Consent • Research with Prisoners • Research in Educational Settings • Instructions • International Research • Defining Research with Human Subjects • Assessing Risk • Privacy and Confidentiality • Research with Children

Depending on the nature of the researcher's studies, additional modules may also be required as appropriate.

A final, overall score of 70% or higher across the modules with tests is required for recertification. Note that not all modules have tests associated with them. A test over any module may be retaken an unlimited number of times to improve the overall score.