


Public reporting burden for this collection of information is estimated to vary from 5 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. **An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number.** Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-0624). Do not return the completed form to this address.

Filling out PDF Forms

This PDF form contains “**roll-over** or **double-click**” help functionality.

This form allows you to enter data directly onto the screen. After completing the form, you are able to print the document so that you can fax/mail the document.

To fill out a form:

1. Select the hand tool. 
2. Position the pointer inside a field, and click to type text.
3. After entering text or selecting a check box, do one of the following:
 - Press tab to accept the form field change and go to the next form field.
 - Press Shift+Tab to accept the form field change and go to the previous form field.
 - Press Enter (Windows) or Return (Mac OS) to accept the form field change and deselect the current form field.
4. Once completed, print the form.

<p>Cancer Trials Support Unit</p> <p><i>Optional form 1</i></p> <p>Withdraw from Protocol Participation</p>	<p>Email, Mail or Fax to: Cancer Trials Support Unit (CTSU) ATTN: Coalition of Cancer Cooperative Groups (CCCCG) Suite 1100 1818 Market Street Philadelphia, PA 19103 FAX: 1-215-569-0206 CTSUSupport@ctsucocccg.org</p>
<p>Institution Name (<i>List all institutions covered by IRB approval that will conducted this study.</i>)</p>	<p>NCI Institution Code : (ALXXX)</p>
<p>Protocol Title: (<i>Short version acceptable</i>)</p>	<p>Protocol Number: (<i>lead Group #</i>)</p>
<p>Rationale for Study Closure: (<i>Select the answer that best describes the closure.</i>)</p>	
<p>1) No subjects were accrued at the institution(s) listed above, and the protocol is now closed to accrual by sponsoring organization.</p>	<input type="checkbox"/>
<p>2) No subjects were accrued at the institution(s) listed above, and the study has been closed with the local IRB with no anticipation of future accrual. (<i>If the protocol is re-opened at a later date the site must submit the CTSU IRB Certification form for an initial approval.</i>)</p>	<input type="checkbox"/>
<p>3) All subjects accrued at local institutions have completed treatment, and follow-up, and no further accruals are anticipated at the institution(s) listed above.</p>	<input type="checkbox"/>
<p>4) IRB/Ethics board responsibilities for the protocol listed above are being transferred to another IRB. Review responsibilities at IRB # _____ are being transferred to IRB# _____. (<i>Please note that the CTSU IRB Certification form must be submitted for the initial review of all protocols under the new IRB. Submission of this form only documents withdraw of approval at the originating IRB.</i>)</p>	<input type="checkbox"/>
<p><i>(The IRB Signatory must sign below if reason #4 is selected. or attach signed letter from IRB.)</i></p>	
<p>Date of IRB/Ethics Board Action: ____ ____ ____ mm dd yyyy</p>	
<p>The institutional staff signing below certifies that the information provided above is correct.</p>	
<p>Name of Signatory:</p>	<p>Name of approving Organization:</p>
<p>Title of Signatory:</p>	<p>Phone (____) ____ - ____ </p>
<p>Signature:</p>	<p>Date: ____/____/____ m m d d y y y y</p>