Provisional Translation (as of April 2019)*

New “Standard Forms for Requesting Clinical Trials, etc.”

July 10, 2018

Research and Development Division, Health Policy Bureau, Ministry of Health, Labour and Welfare
Pharmaceutical Evaluation Division, Pharmaceutical Safety and Environmental Health Bureau, Ministry of Health, Labour and Welfare
Medical Device Evaluation Division, Pharmaceutical Safety and Environmental Health Bureau, Ministry of Health, Labour and Welfare

* This English version of the Japanese original document is provided for reference purposes only. In the event of any inconsistency between the Japanese original and the English translation, the former shall prevail.

[Company-sponsored Clinical Trials/Post-marketing Clinical Studies]

- List of Standard Forms
- Standard Forms
- Precautions for completing Standard Forms

[Investigator-initiated Clinical Trials]

- List of Standard Forms
- Standard Forms
- Precautions for completing Standard Forms

Preamble

1. Basic policy for Standard Forms for Requesting Clinical Trials (hereinafter referred to as "Standard Forms")

   The basic rationale behind the use of the Standard Forms is to simplify and standardize the forms by eliminating requirements necessary for only certain medical institutions (e.g., confirmation seal(s) from the department director) as well as to ensure that clinical trials and related activities are conducted efficiently by promoting compliance with the Standard Forms.

2. Key points concerning the Standard Forms

- The Standard Forms are to be used in connection with clinical trials requested by sponsors (including a person who intends to sponsor a clinical trial) and post-marketing clinical studies requested by post-marketing clinical study sponsors (including a person who intends to sponsor a post-marketing clinical study) (hereinafter collectively referred to as "company-sponsored clinical trials and post-marketing clinical studies") and clinical trials by a person who intends to be a sponsor-investigator (including sponsor-investigators) (hereinafter referred to as "investigator-initiated clinical trials").
- Required information to be provided is limited to the minimum required by the "Ministerial Ordinance on Good Clinical Practice for Drugs" (Ordinance No. 28 by the Ministry of Health and Welfare of 1997) and the "Ministerial Ordinance on Good Clinical Practice for Medical Devices" (Ordinance No. 36 of the Ministry of Health, Labour and Welfare of 2005) (hereinafter collectively referred to as "GCP"); e.g., the provision of information that can be obtained from the protocol is not required.
- The Standard Forms may be used by all medical institutions conducting clinical trials and post-marketing clinical studies.
- The use of a clinical trial document support system that electronically prepares documents compliant with the Standard Forms helps reduce the burden of preparing such documents to the greatest extent.
- The "Reference Forms" refers to forms that are recommended from the perspective that format standardization is reasonable in terms of efficiency, given that various documents are prepared in actual practice. Therefore, the use of Reference Forms is not necessarily mandatory, and other types of forms may also be used.

3. Points to consider regarding the Standard Forms

- There are two types of Standard Forms: those for "company-sponsored clinical trials and post-marketing clinical studies" and those for "investigator-initiated clinical trials".

- There is not a definition for differentiation between the original and duplicate copies or the number of copies required. The Standard Forms for “company-sponsored clinical trials and post-marketing clinical studies” should be used based on the status of the use of electromagnetic records after discussion between the sponsor, the institution and the institutional review board. Similarly, the Standard Forms for “investigator-initiated clinical trials” should be used after discussion between the clinical trial coordinating committee (if applicable), the medical institution and the institutional review board.
- The Standard Forms for “company-sponsored clinical trials and post-marketing clinical studies” and those for “investigator-initiated clinical trials” that are corresponding to each other share the same form number. Therefore, there are some form numbers that are missing (omitted) from the Standard Forms for “investigator-initiated clinical trials,” which have fewer forms. Form 7 is not to be used for both “company-sponsored clinical trials and post-marketing clinical studies” or “investigator-initiated clinical trials”.
- When a serious adverse event is observed in a trial/study subject, the event should be reported using the form for detailed descriptions, regardless of whether the clinical trial/post-marketing clinical study is conducted to study a drug, medical device, or regenerative medical product. However, it may be unavoidable to use other forms approved and defined by the sponsor and the institution (and the institutional review board, as appropriate).
- The Standard Forms may be used as soon as the necessary procedures, including revisions to operating procedures, have been completed.
- To promote the efficient preparation of documents and their retention in the form of electromagnetic records in accordance with the Standard Forms, “Cut Do Square,” a clinical trial document support system, is provided by the Center for Clinical Trials of the Japan Medical Association (hereinafter, the “Center for Clinical Trials”). The necessary information on access to the electronic files of the Standard Forms and the clinical trial document support system is provided as needed on “Clinical Trials,” the website of the Ministry of Health, Labour and Welfare and the website of the Center for Clinical Trials.
- Variability in form format and information included in the forms among medical institutions may not only lead to deviation from the aim of “efficient conduct of clinical trials,” but also preclude the use of the clinical trial document support system. Each medical institution should use the Standard Forms without modifying them, based on the intent of the 5-Year Plan 2012 for the Promotion of Clinical Research and Clinical Trials.
- The necessity of a “seal” should be discussed and determined by the sponsor and the medical institution.
- All Standard Form-based documents can be prepared, issued, and retained as electromagnetic records. As for the use of electromagnetic records, it is important to perform computerization

of all records while ensuring that the electromagnetic records can generate readable output (readability) and are retained while readability is ensured.

- It is also important to take appropriate measures that allow verification of the various processes (e.g., submission and receipt of documents) during the management of clinical trial documents, both for paper and electromagnetic records.

[Reference]

Clinical Trial Promotion Office, Research and Development Division, Health Policy Bureau, Ministry of Health, Labour and Welfare
1-2-2, Kasumigaseki, Chiyoda-ku, Tokyo 100-8916
TEL: 03-5253-1111 (extension: 4165) FAX: 03-3503-0595
E-mail: chikensuishin@mhlw.go.jp

"Clinical Trials" page on the website of Ministry of Health, Labour and Welfare
http://www.mhlw.go.jp/stf/seisakunitsuite/bunya/chiken.html

"Standard Forms" page on the website of the Center for Clinical Trials, Japan Medical Association
http://www.jmacct.med.or.jp/plan/gcp.html#panel3

List of Standard Forms

(For company-sponsored clinical trials/post-marketing clinical studies)

Standard Form No.	Name of document
Form 1	Curriculum Vitae
Form 2	List of Subinvestigator(s) and Clinical Trial Staff Members
Form 3	Clinical Trial Request Form
Form 4	Clinical Trial Review Request Form
Form 5	Clinical Trial Review Results Notification
Form 6	Protocol Modification Report
Form 7	[This form number is not used.]
Form 8	Report concerning Protocol Deviations to Eliminate Immediate Hazards
Form 9	Notification of Protocol Deviations to Eliminate Immediate Hazards
Form 10	Clinical Trial-related Change Application Form
Form 11	Clinical Trial Progress Report
Form 12	Serious Adverse Event Report (For Clinical Trials of Drugs)
Form 13	Serious Adverse Event Report (For Post-Marketing Clinical Studies of Drugs)
Form 14	Serious Adverse Event and Malfunction Report (For Clinical Trials of Medical Devices)
Form 15	Serious Adverse Event and Malfunction Report (For Post-Marketing Clinical Studies of Medical Devices)
Form 16	Safety Information Report
Form 17	Clinical Trial Completion (Premature Termination/Suspension) Report
Form 18	Development Discontinuation Report
Form 19	Serious Adverse Event and Malfunction Report (For Clinical Trials of Regenerative Medical Products)
Form 20	Serious Adverse Event and Malfunction Report (For Post-Marketing Clinical Studies of Regenerative Medical Products)
Form for detailed description	(For detailed description of Forms 12, 13, 14, 15, 19, and 20)
Reference Form 1	Notification of Clinical Trial-related Instructions/Decisions
Reference Form 2	Source Document Verification Application Form

Form 1

Serial No.	

Date: MM/DD/YYYY

Curriculum Vitae

(☐Investigator ☐Subinvestigator)

Japanese syllabaries				
Name				
Name of institution				
Department/title				
Educational record (university)	Name of university	Name of department	Year of graduation	YYYY
License	☐Medical doctor, license # ( )	Year of qualification (		YYYY)
	☐Dentist, license # ( )	Year of qualification (		YYYY)
Qualifications for board-certified physician, etc.				
Employment record (For the previous approx. 5 years)	From MM/YYYY to MM/YYYY :			
	From MM/YYYY to MM/YYYY :			
	From MM/YYYY to MM/YYYY :			
	From MM/YYYY to MM/YYYY :			
	From MM/YYYY to date :			
Specialty				
Affiliated academic societies, etc.				
Major research content, books/literature articles, etc. (Not more than the latest 10 publications related to clinical trial)				
Experience in conducting clinical trials/post-marketing clinical studies (For the previous approx. 2 years)	Trial/study category	Drug	Medical device	Regenerative medical product
	No. of trials/studies (No. of ongoing trials/studies)	XX (YY)	XX (YY)	XX (YY)
	Primary target disease(s)			
	Experience in serving as an investigator (No. of trials/studies): ☐Yes (XX trials/studies) ☐No			
	Experience in serving as a subinvestigator (No. of trials/studies): ☐Yes (XX trials/studies) ☐No			
Remarks*				

*: If you have no experience in conducting clinical trials/post-marketing clinical studies during the previous approximately 2 years, but had experience in conducting them more than 2 years previously, briefly describe the trials/studies that you have been involved in.

Note) (Head of the institution ≠ investigator): This form should be completed by the investigator and then be submitted to the head of the institution and the sponsor.
(Head of the institution = investigator): This form should be completed by the investigator and then be submitted to the sponsor.

Form 2

Serial No.			
Category	☐Clinical trial	☐Post-marketing clinical study	
	☐Drug	☐Medical device	☐Regenerative medical product

Date: MM/DD/YYYY

List of Subinvestigator(s) and Clinical Trial Staff Members (☐New ☐Change)

To: Head of the institution
(Name of the institution) (Title of head officer)

From: Investigator
(Name)

I submit this form to request the inclusion of the individuals specified below as subinvestigator(s)/clinical trial staff members to whom I will delegate the trial-related duties and functions specified below:

Description

Chemical name or identification code of the test drug		Protocol No.	
Clinical trial title			

Name and department/title of the subinvestigator(s) and brief description of duties and functions delegated to the subinvestigator(s) (use separate sheets if there are more than 10 subinvestigators to be listed):

Name	Department or title	Brief description of delegated duties and functions
		☐General clinical trial duties and functions ☐ ( )
		☐General clinical trial duties and functions ☐ ( )
		☐General clinical trial duties and functions ☐ ( )
		☐General clinical trial duties and functions ☐ ( )
		☐General clinical trial duties and functions ☐ ( )
		☐General clinical trial duties and functions ☐ ( )
		☐General clinical trial duties and functions ☐ ( )
		☐General clinical trial duties and functions ☐ ( )
		☐General clinical trial duties and functions ☐ ( )
		☐General clinical trial duties and functions ☐ ( )

Name and department/title of clinical trial staff members and brief description of duties and functions delegated to each member (use separate sheets if there are more than 10 clinical trial staff members to be listed):

Name	Department or title	Brief description of delegated duties and functions
		☐General clinical trial assistant duties and functions ☐ ( )
		☐General clinical trial assistant duties and functions ☐ ( )
		☐General clinical trial assistant duties and functions ☐ ( )
		☐General clinical trial assistant duties and functions ☐ ( )
		☐General clinical trial assistant duties and functions ☐ ( )
		☐General clinical trial assistant duties and functions ☐ ( )
		☐General clinical trial assistant duties and functions ☐ ( )
		☐General clinical trial assistant duties and functions ☐ ( )
		☐General clinical trial assistant duties and functions ☐ ( )
		☐General clinical trial assistant duties and functions ☐ ( )

Date: MM/DD/YYYY

We hereby approve inclusion of the specified individuals as subinvestigator(s)/clinical trial staff members in the list for the above-mentioned clinical trial.

Head of the institution
(Name of the institution) (Title of head officer)

Note) (Head of the institution ≠ investigator): This form should be completed by the investigator and then be submitted to the head of the institution. The head of the institution will fill out the fields for the date of approval and the name of the head of the institution at the bottom of the form and submit the form to the investigator. The head of the institution or the investigator will then submit the form to the sponsor.
(Head of the institution = investigator): This form should be completed by the investigator (the head of the institution). In this case, both the fields for the names of the investigator and the head of the institution at the top of the form and the fields for the date of approval and the name of the head of the institution at the bottom of the form should be filled out. The investigator (head of the institution) will then submit the form to the sponsor.

Form 3

Serial No.			
Category	☐Clinical trial	☐Post-marketing clinical study	
	☐Drug	☐Medical device	☐Regenerative medical product

Date: MM/DD/YYYY

Clinical Trial Request Form

To: Head of the institution
(Name of the institution) (Title of head officer)

From: Sponsor
(Name)
(Representative)

We hereby request to conduct the clinical trial specified below:

Description

Chemical name or identification code of the test drug		Protocol No.	
Clinical trial title	☐New clinical trial ☐Continuation of ongoing clinical trial		
	☐The clinical trial title specified above may be used in the outline of the institutional review board meeting minutes. Note: If you wish to rather use a different clinical trial title than the one specified above, specify it below.		
Duration of the clinical trial	From MM/DD/YYYY to MM/DD/YYYY		
Contact information of the person in charge	Name: Department: TEL: FAX: E-mail:		

List of Attached Documents

Name of document	Date of preparation	Version No.
☐Protocol		
	Date: MM/DD/YYYY	
☐Investigator's Brochure or package insert		
	Date: MM/DD/YYYY	
☐Sample Case Report Form Note: Not required if the information to be provided in the case report form is fully clarified in the protocol.		
	Date: MM/DD/YYYY	
☐Written information for subject and informed consent form		
	Date: MM/DD/YYYY	
☐List of prospective investigator (Curriculum Vitae)		
	Date: MM/DD/YYYY	
☐List of prospective subinvestigators (Name List)		
	Date: MM/DD/YYYY	
☐Document concerning clinical trial expenses (Document concerning subject compensation (if any))		
	Date: MM/DD/YYYY	
☐Document concerning the compensation available to subjects in the event of trial-related injury		
	Date: MM/DD/YYYY	
☐Document concerning subject recruitment procedures (e.g., advertisement)		
	Date: MM/DD/YYYY	
☐Document concerning subject safety		
	Date: MM/DD/YYYY	
☐Others		
	Date: MM/DD/YYYY	

Note) (Head of the institution ≠ investigator): This form should be completed by the sponsor in agreement with the investigator and then be submitted to the head of the institution.
(Head of the institution = investigator): This form should be completed by the sponsor and then be submitted to the head of the institution.

Form 4

Serial No.			
Category	☐Clinical trial	☐Post-marketing clinical study	
	☐Drug	☐Medical device	☐Regenerative medical product

Date: MM/DD/YYYY

Clinical Trial Review Request Form

To: Chairperson of the Institutional Review Board
(Name of the institutional review board)

From: Head of the institution
(Name of the institution) (Title of head officer)

We hereby request to review the following review items:

Description

Sponsor			
Chemical name or identification code of the test drug		Protocol No.	
Clinical trial title			
Name of investigator			
Review items (Attached documents)	☐Appropriateness of conducting the clinical trial (Clinical Trial Request Form [Form 3 dated MM/DD/YYYY]) ☐Appropriateness of continuation of the clinical trial ☐Serious Adverse Event Report Form (☐For Clinical Trials of Drugs [Form 12 dated MM/DD/YYYY]) (☐For Post-Marketing Clinical Studies of Drugs [Form 13 dated MM/DD/YYYY]) (☐For Clinical Trials of Medical Devices [Form 14 dated MM/DD/YYYY]) (☐For Post-Marketing Clinical Studies of Medical Devices [Form 15 dated MM/DD/YYYY]) (☐For Clinical Trials of Regenerative Medical Products [Form 19 dated MM/DD/YYYY]) (☐For Post-Marketing Clinical Studies of Regenerative Medical Products [Form 20 dated MM/DD/YYYY]) ☐Safety information (☐Safety Information Report [Form 16 dated MM/DD/YYYY]) (☐Safety Information Report [Form 16 dated MM/DD/YYYY]) ☐Clinical trial-related changes (☐Clinical Trial-related Change Application Form [Form 10 dated MM/DD/YYYY]) (☐Clinical Trial-related Change Application Form [Form 10 dated MM/DD/YYYY]) ☐Protocol deviations to eliminate immediate hazards (Report concerning Protocol Deviations to Eliminate Immediate Hazards [Form 8 dated MM/DD/YYYY]) ☐Review of the appropriateness of continuation of the clinical trial (Clinical Trial Progress Report [Form 11 dated MM/DD/YYYY]) ☐Others ( )		

Note) This form should be completed by the head of the institution and then be submitted to the institutional review board.

Form 5

Serial No.			
Category	☐Clinical trial	☐Post-marketing clinical study	
	☐Drug	☐Medical device	☐Regenerative medical product

Date: MM/DD/YYYY

Clinical Trial Review Results Notification

To: Head of the institution
(Name of the institution) (Title of head officer)

From: Institutional Review Board
(Name)
(Location)
(Name of the chairperson)

Regarding your request for review, we hereby notify you of the review result as follows:

Description

Chemical name or identification code of the test drug		Protocol No.	
Clinical trial title			
Review items (Review documents)	☐Appropriateness of conducting the clinical trial (Clinical Trial Request Form [Form 3 dated MM/DD/YYYY]) ☐Appropriateness of continuation of the clinical trial ☐Serious Adverse Event Report Form (☐For Clinical Trials of Drugs [Form 12 dated MM/DD/YYYY]) (☐For Post-Marketing Clinical Studies of Drugs [Form 13 dated MM/DD/YYYY]) (☐For Clinical Trials of Medical Devices [Form 14 dated MM/DD/YYYY]) (☐For Post-Marketing Clinical Studies of Medical Devices [Form 15 dated MM/DD/YYYY]) (☐For Clinical Trials of Regenerative Medical Products [Form 19 dated MM/DD/YYYY]) (☐For Post-Marketing Clinical Studies of Regenerative Medical Products [Form 20 dated MM/DD/YYYY]) ☐Safety information (☐Safety Information Report [Form 16 dated MM/DD/YYYY]) (☐Safety Information Report [Form 16 dated MM/DD/YYYY]) ☐Clinical trial-related changes (☐Clinical Trial-related Change Application Form [Form 10 dated MM/DD/YYYY]) (☐Clinical Trial-related Change Application Form [Form 10 dated MM/DD/YYYY]) ☐Protocol deviations to eliminate immediate hazards (Report concerning Protocol Deviations to Eliminate Immediate Hazards [Form 8 dated MM/DD/YYYY]) ☐Review of the appropriateness of continuation of clinical trial (Clinical Trial Progress Report [Form 11 dated MM/DD/YYYY]) ☐Others ( )		
Review category	☐Meeting review (date of review: MM/DD/YYYY) ☐Expedited review (date of the completion of review: MM/DD/YYYY)		
Review result	☐Approval ☐Approval with modifications ☐Disapproval ☐Termination of prior approval ☐Suspension		
Reason etc. for result other than “approval”			
Remarks			

Date: MM/DD/YYYY

To: Sponsor (Name)
To: Investigator (Name)

Regarding the review items of the clinical trial you requested, we hereby notify you of our decision as shown above.

From: Head of the institution
(Name of the institution) (Title of head officer)

Note) If the institutional review board simultaneously submits safety information to the head of the institution, the sponsor, and the investigator ([head of the institution ≠ investigator] only), this form should be completed by the institutional review board, and the field for the date

of notification at the bottom of the form should not be used, but the field for the head of the institution must be filled out as “not applicable.” If safety information is not simultaneously submitted, or in case of other review items than safety information, this form should be completed by the institutional review board and then be submitted to the head of the institution. If the decision made by the institutional review board is consistent with the instructions of the head of the institution, the head of the institution should fill out the fields for the date of the notification and the head of the institution at the bottom of the form, and submit the form to the sponsor and the investigator ([head of the institution ≠ investigator] only). If these are not consistent, Reference Form 1 should be used.
(Head of the institution = investigator): The field for the investigator should be filled out as “not applicable.”

Form 5

Serial No.	

Date: MM/DD/YYYY

List of Attendees/Absentees of the Institutional Review Board Members

Name	Occupation, qualification and department	Member category	Attendances/ absences	Remarks

Note) The category of each member should be described using the following category numbers:
(1) Members whose primary area of interest is in a nonscientific area
(2) Members who are independent of the institution (excluding members falling under category (1))
(3) Members who are independent of the founder of the institutional review board (excluding members falling under category (1))
(4) Members who are not classified as category (1), (2), or (3)

Attendances/absences should be noted using the following category symbols:
○: Members who attended the meeting, and who are not involved in the clinical trial
–: Members who attended the meeting, but did not participate in the review or voting due to involvement in the clinical trial
×: Members who were absent from the meeting

We confirm and guarantee that the institutional review board has been organized and engaged in its activities in accordance with the institutional review board's standard operating procedures, "Ministerial Ordinance on Good Clinical Practice for Drugs" (Ministry of Health and Welfare Ordinance No. 28 of 1997), "Ministerial Ordinance on Good Clinical Practice for Medical Devices" (Ministry of Health, Labour and Welfare Ordinance No. 36 of 2005), "Ordinance on Good Clinical Practice of Regenerative Medical Products, etc." (Ministry of Health, Labour and Welfare Ordinance No. 89 of 2014), "Ministerial Ordinance on Good Post-Marketing Clinical Study Practice for Drugs" (Ministry of Health, Labour and Welfare Ordinance No. 171 of 2004), "Ministerial Ordinance on Good Post-Marketing Clinical Study Practice for Medical Devices" (Ministry of Health, Labour and Welfare Ordinance No. 38 of 2005), and "Ministerial Ordinance on Good Post-Marketing Clinical Study Practice for Regenerative Medical Products" (Ministry of Health, Labour and Welfare Ordinance No. 90 of 2014).

Form 6

Serial No.			
Category	☐Clinical trial	☐Post-marketing clinical study	
	☐Drug	☐Medical device	☐Regenerative medical product

Date: MM/DD/YYYY

Protocol Modification Report

To: Head of the institution
(Name of the institution) (Title of head officer)

From: Sponsor
(Name)
(Representative)
From: Investigator
(Name)

Regarding the protocol notified as "approval with modifications" on MM/DD/YYYY, we hereby report that the protocol has been modified as follows:

Description

Chemical name or identification code of the test drug		Protocol No.	
Clinical trial title			
Condition/reason etc. for "approval with modifications"			
Action taken	Before modification	After modification	
Attached documents			
Contact information of the person in charge	Name: Department: TEL: FAX: E-mail:		

Regarding the clinical trial specified above, we have confirmed that the modification above meets the condition for approval.

Date: MM/DD/YYYY

Head of the institution
(Name of the institution) (Title of head officer)

Note) (Head of the institution ≠ investigator): This form should be completed by the sponsor in agreement with the investigator and then be submitted to the head of the institution. The head of the institution will fill out the fields for the date of confirmation and the head of the institution at the bottom of the form. Depending on the action taken, this form should be completed by the investigator and then be submitted to the head of the institution. In this case, the field for the sponsor must be filled out as "not applicable."
(Head of the institution = investigator): This form should be completed by the sponsor and then be submitted to the head of the institution. The field for the investigator should be filled out as "not applicable." The head of the institution will fill out the fields for the date of confirmation and the head of the institution at the bottom of the form. Depending on the action taken, the investigator (the head of the institution) may complete the form, and fill out both the fields for the investigator and the head of the institution at the top of the form and the fields for the date of confirmation and the head of the institution at the bottom of the form. In this case, the field for the sponsor must be filled out as "not applicable."

Form 8

Serial No.			
Category	☐Clinical trial	☐Post-marketing clinical study	
	☐Drug	☐Medical device	☐Regenerative medical product

Date: MM/DD/YYYY

Report concerning Protocol Deviations to Eliminate Immediate Hazards

To: Head of the institution
(Name of the institution) (Title of head officer)
Sponsor
(Name)

From: Investigator
(Name)

Regarding the clinical trial specified below, I hereby report the occurrence of the following protocol deviation to eliminate immediate hazards to subjects:

Description

Chemical name or identification code of the test drug		Protocol No.	
Clinical trial title			

Subject identification code	

Description of the deviation (With the name of document[s], if attached)	Reason for the deviation

Note) (Head of the institution ≠ investigator): This form should be completed by the investigator and then be submitted to the sponsor and the head of the institution.
(Head of the institution = investigator): This form should be completed by the investigator and then be submitted to the sponsor. In this case, both the fields for the investigator and the head of the institution should be filled out.

Form 9

Serial No.			
Category	☐Clinical trial	☐Post-marketing clinical study	
	☐Drug	☐Medical device	☐Regenerative medical product

Date: MM/DD/YYYY

Notification of Protocol Deviations to Eliminate Immediate Hazards

To: Head of the institution
(Name of the institution) (Title of head officer)

From: Sponsor
(Name)
(Representative)

Regarding your previous "Report concerning Protocol Deviations to Eliminate Immediate Hazards" received on MM/DD/YYYY for the clinical trial specified below, we hereby notify you of the results of our review, as follows:

Description

Chemical name or identification code of the test drug		Protocol No.	
Clinical trial title			
Review result	The deviation as an action taken for a medically unavoidable reason (e.g., to eliminate immediate hazards to the subject) is: ☐Agreed ☐Not agreed		
Reason, etc. if not agreeing			
Contact information of the person in charge	Name:	Department:	
	TEL:	FAX:	E-mail:

Note) This form should be completed by the sponsor and then be submitted to the head of the institution.
(Head of the institution ≠ investigator): The head of the institution will submit this form to the investigator.

Form 10

Serial No.			
Category	☐Clinical trial	☐Post-marketing clinical study	
	☐Drug	☐Medical device	☐Regenerative medical product

Date: MM/DD/YYYY

Clinical Trial-related Change Application Form

To: Head of the institution
(Name of the institution) (Title of head officer)

From: Sponsor
(Name)
(Representative)
From: Investigator
(Name)

Regarding the clinical trial specified below, we hereby apply for the following change:

Description

Chemical name or identification code of the test drug			Protocol No.	
Clinical trial title				
Document, etc. subject to the change	☐Protocol ☐Written information for subjects and informed consent form ☐Investigator's Brochure ☐Subinvestigator ☐Others ( )			
Description of the change	Change	Before change	After change	Reason for change
Attached documents				
Contact information of the person in charge	Name: Department: TEL: FAX: E-mail:			

Note) (Head of the institution ≠ investigator): This form should be completed by the sponsor in agreement with the investigator and then be submitted to the head of the institution. Depending on the change, this form should be completed by the investigator and then be submitted to the head of the institution. In this case, the field for the sponsor must be filled in out as "not applicable."
(Head of the institution = investigator): This form should be completed by the sponsor and then be submitted to the head of the institution. The field for the investigator should be filled out as "not applicable." Depending on the change, the investigator (the head of the institution) may complete the form. In this case, both the fields for the investigator and the head of the institution should be filled out, and the field for the sponsor must be filled out as "not applicable."

Form 11

Serial No.			
Category	☐Clinical trial	☐Post-marketing clinical study	
	☐Drug	☐Medical device	☐Regenerative medical product

Date: MM/DD/YYYY

Clinical Trial Progress Report

To: Head of the institution
(Name of the institution) (Title of head officer)

From: Investigator
(Name)

I hereby report the progress of the clinical trial specified below as follows:

Description

Sponsor			
Chemical name or identification code of the test drug		Protocol No.	
Clinical trial title			
Actual status	No. of subjects from whom informed consent has been obtained: XX No. of subjects enrolled in the trial: XX (including YY subjects who completed the protocol and ZZ subjects who withdrew from the trial) (As of MM/DD/YYYY)		
Duration of the clinical trial	From MM/DD/YYYY to MM/DD/YYYY		
Progress of the clinical trial	Safety Compliance with GCP Others (e.g., reasons for subject withdrawal from the trial)		

Note) (Head of the institution ≠ investigator): This form should be completed by the investigator and then be submitted to the head of the institution.
(Head of the institution = investigator): This form should be completed by the head of the institution (the investigator). In this case, both the fields for the investigator and the head of the institution should be filled out.

Form 12

Serial No.	
Category	■Clinical trial ■Drug

Date: MM/DD/YYYY

Serious Adverse Event Report (XXth Report)

To: Head of the institution
(Name of the institution) (Title of head officer)
To: Sponsor
(Name)

From: Investigator
(Name)

I hereby report that the following adverse event determined to be serious was observed in the clinical trial specified below:

Description

Chemical name or identification code of the test drug		Protocol No.	
Clinical trial title			

Subject identification code*	

*: If the event was observed in a fetus/offspring, the identification code of the subject (parent) should be provided.

Information concerning the individual experiencing the serious adverse event

Category of the individual experiencing the event ☐Subject ☐Fetus ☐Offspring	Body weight: kg Height: cm	Date of birth (MM/DD/YYYY): / / Age: XX (XX weeks of age [for fetus])	Predisposition of the subject (e.g., hypersensitivity) ☐No ☐Yes ( )
	Sex: ☐Male ☐Female	Date of menstruation before event onset (MM/DD/YYYY): / / (Gestation at event onset in the fetus: XX weeks)	

Information concerning the serious adverse event

Detailed information ☐Yes (☐Standard Forms ☐Other forms) ☐No

Event term (diagnosis) Expectedness of event with respect to the investigational product	Date of event onset (MM/DD/YYYY)	Reason why event was determined to be serious Date when event was determined to be serious (MM/DD/YYYY)	Outcome of the event Date when the outcome was determined (MM/DD/YYYY)
☐Expected ☐Unexpected	/ /	(/ /) ☐Results in death ☐Is life-threatening ☐Requires inpatient hospitalization or prolongation of existing hospitalization ☐Results in persistent or significant disability/incapacity ☐Is a congenital anomaly/birth defect ☐Other important medical events	(/ /) ☐Recovered/resolved ☐Recovering/resolving ☐Not Recovered/not resolved/ongoing ☐Recovered/resolved with sequelae ☐Fatal ☐Unknown

Information concerning the investigational product

Investigational product	Treatment duration (MM/DD/YYYY)	Causal relationship with the event	Action taken after event onset Dosage regimen after dose modification
☐Test drug (blinded) ☐Test drug ☐Others	/ / to ☐ / / ☐Ongoing	☐Related ☐Not related	☐Drug withdrawn ☐Unchanged ☐Unknown ☐Not applicable ☐Dose reduced ☐Dose increased
Name of the drug: Brand/nonproprietary name	Dosage regimen during the treatment period		Dosage regimen after dose modification

Remarks: For clinical trials of combination products, it should be clarified that there are other report forms related to this report. Other comments, if any, should also be provided.

Attached documents	

Note) (Head of the institution ≠ investigator): This form should be completed by the investigator and then be submitted to the head of the institution and the sponsor.
(Head of the institution = investigator): This form should be completed by the investigator and then be submitted to the sponsor. In this case, both the fields for the investigator and the head of the institution should be filled out.

Form 13

Serial No.	
Category	■Post-marketing clinical study ■Drug

Date: MM/DD/YYYY

Serious Adverse Event Report (XXth Report)

To: Head of the institution
(Name of the institution) (Title of head officer)
To: Post-Marketing Clinical Study Sponsor
(Name)

From: Post-Marketing Clinical Study Investigator
(Name)

I hereby report that the following adverse event determined to be serious was observed in the study specified below:

Description

Chemical name or identification code of the test drug		Post-marketing clinical study protocol No.	
Post-marketing clinical study title			

Subject identification code*	

*: If the event was observed in a fetus/offspring, the identification code of the subject (parent) should be provided.

Information concerning the individual experiencing the serious adverse event

Category of the individual experiencing the event ☐Subject ☐Fetus ☐Offspring	Body weight: kg Height: cm	Date of birth (MM/DD/YYYY): / / Age: XX (XX weeks of age [for fetus])	Predisposition of the subject (e.g., hypersensitivity) ☐No ☐Yes ( )
	Sex: ☐Male ☐Female	Date of menstruation before event onset (MM/DD/YYYY): / / (Gestation at event onset in the fetus: XX weeks)	

Information concerning the serious adverse event

Detailed information ☐Yes (☐Standard Forms ☐Other forms) ☐No

Event term (diagnosis) Expectedness for the study drug	Date of event onset (MM/DD/YYYY)	Reason why event was determined to be serious Date when event was determined to be serious (MM/DD/YYYY)	Outcome of the event Date when the outcome was determined (MM/DD/YYYY)
☐Expected ☐Unexpected	/ /	(/ /) ☐Results in death ☐Is life-threatening ☐Requires inpatient hospitalization or prolongation of existing hospitalization ☐Results in persistent or significant disability/incapacity ☐Is a congenital anomaly/birth defect ☐Other important medical events	(/ /) ☐Recovered/resolved ☐Recovering/resolving ☐Not recovered/not resolved/ongoing ☐Recovered/resolved with sequelae ☐Fatal ☐Unknown

Information concerning the post-marketing clinical study drug

Post-marketing clinical study drug	Treatment duration (MM/DD/YYYY)	Causal relationship with the event	Action taken after event onset Dosage regimen after dose modification
☐Test drug (blinded) ☐Test drug ☐Others	/ / to ☐ / / ☐Ongoing	☐Related ☐Not related	☐Drug withdrawn ☐Unchanged ☐Unknown ☐Not applicable ☐Dose reduced ☐Dose increased
Name of the drug: Brand/nonproprietary name	Dosage regimen during the treatment period		Dosage regimen after dose modification

Remarks: For post-marketing clinical studies of combination products, it should be clarified that there are other report forms related to this report. Other comments, if any, should also be provided.

Attached documents	

Note) (Head of the institution ≠ investigator): This form should be completed by the post-marketing clinical study investigator and then be submitted to the head of the institution and the post-marketing clinical study sponsor.
(Head of the institution = investigator): This form should be completed by the post-marketing clinical study investigator and then be submitted to the post-marketing clinical study sponsor. In this case, both fields for the post-marketing clinical study investigator and the head of the institution should be filled out.

Form 14

Serial No.	
Category	■ Clinical trial ■ Medical device

Date: MM/DD/YYYY

Serious Adverse Event and Malfunction Report (XXth Report)

To: Head of the institution
(Name of the institution) (Title of head officer)
To: Sponsor
(Name)

From: Investigator
(Name)

I hereby report that the following ☐adverse event determined to be serious ☐malfunction that may cause a serious adverse event was observed in the clinical trial specified below:

Description

Name of material or identification code of the test device		Protocol No.	
Clinical trial title			

Subject identification code*	

*: If the event was observed in a fetus/offspring, the identification code of the subject (parent) should be provided.

Information concerning the individual experiencing the serious adverse event, etc.

Category of the individual experiencing the event ☐Subject ☐Fetus ☐Offspring ☐Others ( )	Body weight: kg Height: cm	Date of birth (MM/DD/YYYY): / / Age: XX (XX weeks of age [for fetus])	Predisposition of the subject (e.g., hypersensitivity) ☐No ☐Yes ( )
	Sex: ☐Male ☐Female	Date of menstruation before event onset (MM/DD/YYYY): / / (Gestation at event onset in the fetus: XX weeks)	

Information concerning the serious adverse event

Detailed information ☐Yes (☐Standard Forms ☐Other forms) ☐No ☐Not applicable

Event term (diagnosis) Expectedness for the investigational device	Date of event onset (MM/DD/YYYY)	Reason why event was determined to be serious Date when event was determined to be serious (MM/DD/YYYY)	Outcome of the event Date when the outcome was determined (MM/DD/YYYY)
☐Expected ☐Unexpected	/ /	(/ /) ☐Results in death ☐Is life-threatening ☐Requires inpatient hospitalization or prolongation of existing hospitalization ☐Results in persistent or significant disability/incapacity ☐Is a congenital anomaly/birth defect ☐Other important medical events	(/ /) ☐Recovered/resolved ☐Recovering/resolving ☐Not recovered/not resolved/ongoing ☐Recovered/resolved with sequelae ☐Fatal ☐Unknown ☐Not applicable

Information concerning the investigational device (including procedures)

Investigational device etc.	Date/duration of use (MM/DD/YYYY)	Causal relationship with the event	Action taken against the event caused by the investigational device
☐Procedure	/ / to ☐ / / ☐Ongoing	☐Related ☐Probably related ☐Possibly related ☐Not related ☐Unknown ☐Not applicable	

☐Test device (blinded) ☐Test device ☐Others Lot No.	/ / to ☐ / / ☐Currently in use	☐Related ☐Probably related ☐Possibly related ☐Not related ☐Unknown ☐Not applicable	☐Yes ☐No ☐Not applicable

Note) (Head of the institution ≠ investigator): This form should be completed by the investigator and then be submitted to the head of the institution and the sponsor.
(Head of the institution = investigator): This form should be completed by the investigator and then be submitted to the sponsor. In this case, both the fields for the investigator and the head of the institution should be filled out.

Form 14

Serial No.	

Information concerning the investigational device malfunction ☐Not applicable

Name of the device malfunction			☐Expected ☐Unexpected
Date of onset of the investigational device malfunction	(HH:MM on MM/DD/YYYY): / / :		
Possible cause of the investigational device malfunction	Transportation/ storage	☐Yes Specify: ☐No	
	Procedure	☐Yes Specify: ☐No	
	Concomitant medications Concomitant therapies	☐Yes Specify: ☐No	
	Others		
Description of the investigational device malfunction	Specify the clinical course of the malfunction of the investigational device (including procedures) and the condition of the investigational device (e.g., structural/material/functional defect). If the device malfunction occurred after use of the device, clarify whether the device has been left in the body or has been removed.		

Reason for considering that the investigational device malfunction may cause a serious adverse event

Remarks: For clinical trials of combination products, it should be clarified that there are other report forms related to this report. Other comments, if any, should also be provided.

Attached documents	

Form 15

Serial No.	
Category	■Post-marketing clinical study ■Medical device

Date: MM/DD/YYYY

Serious Adverse Event and Malfunction Report (XXth Report)

To: Head of the institution
(Name of the institution) (Title of head officer)
To: Post-Marketing Clinical Study Sponsor
(Name)

From: Post-Marketing Clinical Study Investigator
(Name)

I hereby report that the following ☐adverse event determined to be serious ☐malfunction that may cause a serious adverse event was observed in the post-marketing clinical study specified below:

Description

Name of material or identification code of the test device		Post-marketing clinical study protocol No.	
Post-marketing clinical study title			

Subject identification code*	

*: If the event was observed in a fetus/offspring, the identification code of the subject (parent) should be provided.

Information concerning the individual experiencing the serious adverse event, etc.

Category of the individual experiencing the event ☐Subject ☐Fetus ☐Offspring ☐Others ( )	Body weight: kg Height: cm	Date of birth (MM/DD/YYYY): / / Age: XX (XX weeks of age [for fetus])	Predisposition of the subject (e.g., hypersensitivity) ☐No ☐Yes ( )
	Sex: ☐Male ☐Female	Date of menstruation before event onset (MM/DD/YYYY): / / (Gestation at event onset in the fetus: XX weeks)	

Information concerning the serious adverse event

Detailed information ☐Yes (☐Standard forms ☐Other forms) ☐No ☐Not applicable

Event term (diagnosis) Expectedness for the study device	Date of event onset (MM/DD/YYYY)	Reason why event was determined to be serious Date when event was determined to be serious (MM/DD/YYYY)	Outcome of the event Date when the outcome was determined (MM/DD/YYYY)
☐Expected ☐Unexpected	/ /	(/ /) ☐Results in death ☐Is life-threatening ☐Requires inpatient hospitalization or prolongation of existing hospitalization ☐Results in persistent or significant disability/incapacity ☐Is a congenital anomaly/birth defect ☐Other important medical events	(/ /) ☐Recovered/resolved ☐Recovering/resolving ☐Not recovered/not resolved/ongoing ☐Recovered/resolved with sequelae ☐Fatal ☐Unknown ☐Not applicable

Information concerning the post-marketing clinical study device (including procedures)

Study device, etc.	Date/duration of use (MM/DD/YYYY)	Causal relationship with the event	Action taken against the event caused by the study device
☐Procedure	/ / to ☐ / / ☐Ongoing	☐Related ☐Probably related ☐Possibly related ☐Not related ☐Unknown ☐Not applicable	
☐Test device (blinded)	/ / to ☐ / / ☐Currently in use	☐Related ☐Probably related	☐Yes ☐No

☐Test device ☐Others Lot No.		☐Possibly related ☐Not related ☐Unknown ☐Not applicable	☐Not applicable

Note) (Head of the institution ≠ investigator): This form should be completed by the post-marketing clinical study investigator and then be submitted to the head of the institution and the post-marketing clinical study sponsor.
(Head of the institution = investigator): This form should be completed by the post-marketing clinical study investigator and then be submitted to the post-marketing clinical study sponsor. In this case, both fields for the post-marketing clinical study investigator and the head of the institution should be filled out.

Form 15

Serial No.	

Information concerning the post-marketing clinical study device malfunction ☐Not applicable

Name of the device malfunction			☐Expected ☐Unexpected
Date of onset of the study device malfunction	(HH:MM on MM/DD/YYYY): / / :		
Possible cause of the study device malfunction	Transportation/ storage	☐Yes Specify: ☐No	
	Procedure	☐Yes Specify: ☐No	
	Concomitant medications Concomitant therapies	☐Yes Specify: ☐No	
	Others		
Description of the study device malfunction	Specify the clinical course of the malfunction of the study device (including procedures) and the condition of the study device (e.g., structural/material/functional defect). If the device malfunction occurred after use of the device, clarify whether the device has been left in the body or has been removed.		

Reason for considering that the study device malfunction may cause a serious adverse event

Remarks: For post-marketing clinical studies of combination products, it should be clarified that there are other report forms related to this report. Other comments, if any, should also be provided.

Attached documents	

Form 16

Serial No.			
Category	☐Clinical trial	☐Post-marketing clinical study	
	☐Drug	☐Medical device	☐Regenerative medical product

Date: MM/DD/YYYY

Safety Information Report

To: Head of the institution
(Name of the institution) (Title of head officer)
To: Investigator
(Name)
To: Chairperson of the Institutional Review Board
(Name of the institutional review board)

From: Sponsor
(Name)
(Representative)

We hereby report that the following information was obtained in the clinical trial specified below:

Description

Chemical name or identification code of the test drug		Protocol No.	
Clinical trial title			
Outline of the safety information	☐Individual case report ☐1. Resulting in death/ life-threatening (☐Domestic ☐Foreign) ☐2. Other serious (☐Domestic ☐Foreign)		
	☐Annual report (Reporting period: MM/DD/YYYY to MM/DD/YYYY) ☐Research report ☐Safety measure report ☐Notices of Revision of Precautions ☐Others ( )		
Sponsor's opinion	Continuation of the clinical trial ☐Yes ☐No Revision of the protocol ☐Not required ☐Required Revision of the written information for subjects and informed consent form (sample) ☐Not required ☐Required Others ( )		
Attached documents			
Remarks			
Contact information of the person in charge	Name: Department: TEL: FAX: E-mail:		

Note) If this form is not submitted to the institutional review board, the field for the name of the institutional review board must be filled out as "not applicable."
(Head of the institution ≠ investigator): This form should be completed by the sponsor and then be submitted to the head of the institution and the investigator. If it is agreed in advance to submit it to the institutional review board, the form should also be submitted to the institutional review board.
(Head of the institution = investigator): This form should be completed by the sponsor and then be submitted to the head of the institution (investigator). If it is agreed in advance to submit it to the institutional review board, the form should also be submitted to the institutional review board.

Form 17

Serial No.			
Category	☐Clinical trial	☐Post-marketing clinical study	
	☐Drug	☐Medical device	☐Regenerative medical product

Date: MM/DD/YYYY

Clinical Trial Completion (Premature Termination/Suspension) Report

To: Head of the institution
(Name of the institution) (Title of head officer)

From: Investigator
(Name)

I hereby report that the clinical trial specified below was ☐completed ☐prematurely terminated ☐suspended as follows:

Description

Chemical name or identification code of the test drug		Protocol No.	
Clinical trial title			
Actual status	No. of subjects from whom informed consent has been obtained: XX No. of subjects enrolled in the trial: XX		
Duration of the clinical trial	From MM/DD/YYYY to MM/DD/YYYY		
Overview of clinical trial results, etc. (If the trial was prematurely terminated or suspended, specify the reason.)	Efficacy Safety Compliance with GCP Others		

Date: MM/DD/YYYY

To: Chairperson of the Institutional Review Board (Name of the institutional review board)
To: Sponsor (Name)

Regarding the clinical trial specified above, we hereby notify as stated above.

From: Head of the institution
(Name of the institution) (Title of head officer)

Note) (Head of the institution ≠ investigator): This form should be completed by the investigator and then be submitted to the head of the institution. The head of the institution will fill out the fields for the date of notification and the head of the institution at the bottom of the form, and submit the form to the institutional review board and the sponsor.
(Head of the institution = investigator): This form should be completed by the investigator (the head of the institution). In this case, both the fields for the investigator and the head of the institution at the top of the form and the fields for the date of notification and the head of the institution at the bottom of the form should be filled out, and the form should be submitted to the institutional review board and the sponsor.

Form 18

Serial No.			
Category	☐Clinical trial	☐Post-marketing clinical study	
	☐Drug	☐Medical device	☐Regenerative medical product

Date: MM/DD/YYYY

Development Discontinuation Report

To: Head of the institution
(Name of the institution) (Title of head officer)

From: Sponsor
(Name)
(Representative)

Regarding the clinical trial specified below that we requested you to conduct, we hereby report as follows:

Description

Chemical name or identification code of the test drug		Protocol No.	
Clinical trial title			
Duration of the clinical trial	From MM/DD/YYYY to MM/DD/YYYY		
Information reported	☐For the reason specified in the attachment, we, on MM/DD/YYYY will: ☐Discontinue the development of the test drug ☐Prematurely terminate the clinical trial ☐Suspend the clinical trial ☐Obtainment of marketing approval (Date: MM/DD/YYYY) ☐Notification of results of reexamination/reevaluation (Date: MM/DD/YYYY)		
Document retention, etc.	Regarding clinical trial documents currently retained at your institution, follow the following procedure: ☐Discard the documents. ☐Retain the documents until MM/DD/YYYY. ☐Others ( )		
Contact information of the person in charge	Name: Department: TEL: FAX: E-mail:		

Date: MM/DD/YYYY

To: Chairperson of the Institutional Review Board (Name of the institutional review board)
To: Investigator (Name)

Regarding the clinical trial specified above, we hereby notify that we have received the above report from the sponsor:

From: Head of the institution
(Name of the institution) (Title of head officer)

Note) If "Obtainment of marketing approval" or "Notification of result of reexamination/reevaluation" is selected as the information reported, with the decision that submission of the form to the institutional review board is not required, the field for the institutional review board must be filled out as "not applicable."
(Head of the institution ≠ investigator): This form should be completed by the sponsor and then be submitted to the head of the institution. The head of the institution will fill out the fields for the date of notification and the head of the institution at the bottom of the form and submit the form to the institutional review board and the investigator.
(Head of the institution = investigator): This form should be completed by the sponsor and then be submitted to the head of the institution. The head of the institution will fill out the fields for the date of notification and the head of the institution at the bottom of the form and submit the form to the institutional review board. The field for the investigator should be filled out as "not applicable."

Form 19

Serial No.	
Category	■Clinical trial ■Regenerative medical product

Date: MM/DD/YYYY

Serious Adverse Event and Malfunction Report (XXth Report)

To: Head of the institution
(Name of the institution) (Title of head officer)
To: Sponsor
(Name)

From: Investigator
(Name)

I hereby report that the following ☐adverse event determined to be serious ☐malfunction that may cause a serious adverse event was observed in the clinical trial specified below:

Description

Name of material or identification code of the test product		Protocol No.	
Clinical trial title			

Subject identification code*	

*: If the event was observed in a fetus/offspring, the identification code of the subject (parent) should be provided.

Information concerning the individual experiencing the serious adverse event, etc.

Category of the individual experiencing the event ☐Subject ☐Fetus ☐Offspring ☐Others ( )	Body weight: kg Height: cm	Date of birth (MM/DD/YYYY): / / Age: XX (XX weeks of age [for fetus])	Predisposition of the subject (e.g., hypersensitivity) ☐No ☐Yes ( )
	Sex: ☐Male ☐Female	Date of menstruation before event onset (MM/DD/YYYY): / / (Gestation at event onset in the fetus: XX weeks)	

Information concerning the serious adverse event

Detailed information ☐Yes (☐Standard Forms ☐Other forms) ☐No ☐Not applicable

Event term (diagnosis) Expectedness of event with respect to the investigational product	Date of event onset (MM/DD/YYYY)	Reason why event was determined to be serious Date when event was determined to be serious (MM/DD/YYYY)	Outcome of the event Date when the outcome was determined (MM/DD/YYYY)
☐Expected ☐Unexpected	/ /	(/ /) ☐Results in death ☐Is life-threatening ☐Requires inpatient hospitalization or prolongation of existing hospitalization ☐Results in persistent or significant disability/incapacity ☐Is a congenital anomaly/birth defect ☐Other important medical events	(/ /) ☐Recovered/resolved ☐Recovering/resolving/ongoing ☐Not recovered/not resolved ☐Recovered/resolved with sequelae ☐Fatal ☐Unknown ☐Not applicable

Information concerning the investigational product (including procedures)

Investigational product, etc.	Date/duration of use (MM/DD/YYYY)	Causal relationship with the event	Action taken against the event caused by the investigational product
☐Procedure**	/ / to ☐ / / ☐Ongoing	☐Related ☐Probably related ☐Possibly related ☐Not related ☐Unknown ☐Not applicable	

☐Test product (blinded) ☐Test product ☐Others Lot No.	/ / to ☐ / / ☐Currently in use	☐Related ☐Probably related ☐Possibly related ☐Not related ☐Unknown ☐Not applicable	☐Yes ☐No ☐Not applicable

**: Procedures include a series of pretreatments/preparation for cell sampling.

Note) (Head of the institution ≠ investigator): This form should be completed by the investigator and then be submitted to the head of the institution and the sponsor.
(Head of the institution = investigator): This form should be completed by the investigator and then be submitted to the sponsor. In this case, both the fields for the investigator and the head of the institution should be filled out.

Form 19

Serial No.	

Information concerning the investigational product malfunction ☐Not applicable

Name of the product malfunction		☐Expected ☐Unexpected
Date of onset of the investigational product malfunction	(HH:MM on MM/DD/YYYY): / / :	
Possible cause of the investigational product malfunction	Transportation/ storage	☐Yes Specify: ☐No
	Procedure	☐Yes Specify: ☐No
	Underlying diseases	☐Yes Specify: ☐No
	Concomitant medications Concomitant therapies	☐Yes Specify: ☐No
	Others	
Description of the investigational product malfunction	Specify the clinical course of the malfunction of the investigational product (including procedures) and the condition of the investigational product (e.g., structural/material/functional defect). If the product malfunction occurred after use of the product, clarify whether the product has been left in the body or has been removed.	

Reason for considering that the investigational product malfunction may cause a serious adverse event

Remarks: For clinical trials of combination products, it should be clarified that there are other report forms related to this report if more than one malfunction has to be reported. Other comments, if any, should also be provided.

Attached documents	

Form 20

Serial No.	
Category	■Post-marketing clinical study ■Regenerative medical product

Date: MM/DD/YYYY

Serious Adverse Event and Malfunction Report (XXth Report)

To: Head of the institution
(Name of the institution) (Title of head officer)
To: Post-Marketing Clinical Study Sponsor
(Name)

From: Post-Marketing Clinical Study Investigator
(Name)

I hereby report that the following ☐adverse event determined to be serious ☐malfunction that may cause a serious adverse event was observed in the post-marketing clinical study specified below:

Description

Name of material or identification code of the test product		Post-marketing clinical study protocol No.	
Post-marketing clinical study title			

Subject identification code*	

*: If the event was observed in a fetus/offspring, the identification code of the subject (parent) should be provided.

Information concerning the individual experiencing the serious adverse event, etc.

Category of the individual experiencing the event ☐Subject ☐Fetus ☐Offspring ☐Others ( )	Body weight: kg Height: cm	Date of birth (MM/DD/YYYY): / / Age: XX (XX weeks of age [for fetus])	Predisposition of the subject (e.g., hypersensitivity) ☐No ☐Yes ( )
	Sex: ☐Male ☐Female	Date of menstruation before event onset (MM/DD/YYYY): / / (Gestation at event onset in the fetus: XX weeks)	

Information concerning the serious adverse event

Detailed information ☐Yes (☐Standard Forms ☐Other forms) ☐No ☐Not applicable

Event term (diagnosis) Expectedness of event with respect to the study product	Date of event onset (MM/DD/YYYY)	Reason why event was determined to be serious Date when event was determined to be serious (MM/DD/YYYY)	Outcome of the event Date when the outcome was determined (MM/DD/YYYY)
☐Expected ☐Unexpected	/ /	(/ /) ☐Results in death ☐Is life-threatening ☐Requires inpatient hospitalization or prolongation of existing hospitalization ☐Results in persistent or significant disability/incapacity ☐Is a congenital anomaly/birth defect ☐Other important medical events	(/ /) ☐Recovered/resolved ☐Recovering/resolving ☐Not Recovered/not resolved/ongoing ☐Recovered/resolved with sequelae ☐Fatal ☐Unknown ☐Not applicable

Information concerning the post-marketing clinical study product (including procedures)

Study product, etc.	Date/duration of use (MM/DD/YYYY)	Causal relationship with the event	Action taken against the event caused by the study product
☐Procedure**	/ / to ☐ / / ☐Ongoing	☐Related ☐Probably related ☐Possibly related ☐Not related ☐Unknown ☐Not applicable	
☐Test product (blinded)	/ / to ☐ / / ☐Currently in use	☐Related ☐Probably related	☐Yes ☐No

☐Test product ☐Others Lot No.		☐Possibly related ☐Not related ☐Unknown ☐Not applicable	☐Not applicable

**: Procedures include a series of pretreatments/preparation for cell sampling.

Note) (Head of the institution ≠ investigator): This form should be completed by the post-marketing clinical study investigator and then be submitted to the head of the institution and the post-marketing clinical study sponsor.
(Head of the institution = investigator): This form should be completed by the post-marketing clinical study investigator and then be submitted to the post-marketing clinical study sponsor. In this case, both the fields for the investigator and the head of the institution should be filled out.

Form 20

Serial No.	

Information concerning the malfunction of the post-marketing clinical study product ☐Not applicable

Name of the product malfunction		☐Expected ☐Unexpected
Date of onset of the study product malfunction	(HH:MM on MM/DD/YYYY): / / :	
Possible causes of the study product malfunction	Transportation/ storage	☐Yes Specify: ☐No
	Procedure	☐Yes Specify: ☐No
	Underlying diseases	☐Yes Specify: ☐No
	Concomitant medications Concomitant therapies	☐Yes Specify: ☐No
	Others	
Description of the study product malfunction	Specify the clinical course of the malfunction of the study product (including procedures) and the condition of the study product (e.g., structural/material/functional defect). If the product malfunction occurred after use of the product, clarify whether the product has been left in the body or has been removed.	

Reason for considering that the study product malfunction may cause a serious adverse event

Remarks: For post-marketing clinical studies of combination products, it should be clarified that there are other report forms related to this report if more than one malfunction has to be reported. Other comments, if any, should also be provided.

Attached documents	

Form for detailed description

Serial No.	

Underlying diseases, complicating conditions, medical history, and previous treatments believed to be related to the serious adverse event (e.g., surgical procedures, radiotherapy, blood transfusion, etc.)

	Name of disease	Date of onset (MM/DD/YYYY)	Status at the time of reporting (MM/DD/YYYY)
Underlying diseases, complicating conditions, and medical history		/ /	☐Persisting ☐Cured (/ /) ☐Unknown
		/ /	☐Persisting ☐Cured (/ /) ☐Unknown
		/ /	☐Persisting ☐Cured (/ /) ☐Unknown
		/ /	☐Persisting ☐Cured (/ /) ☐Unknown
		/ /	☐Persisting ☐Cured (/ /) ☐Unknown
		/ /	☐Persisting ☐Cured (/ /) ☐Unknown
		/ / / /	☐Persisting ☐Cured (/ /) ☐Unknown
		/ / / /	☐Persisting ☐Cured (/ /) ☐Unknown

Surgical procedures, radiotherapy, blood transfusion, etc.	Date of initiation (MM/DD/YYYY)	Status at the time of reporting (MM/DD/YYYY)
	/ /	☐Persisting ☐Cured (/ /) ☐Unknown
	/ /	☐Persisting ☐Cured (/ /) ☐Unknown
	/ /	☐Persisting ☐Cured (/ /) ☐Unknown

Medications used at the onset of the serious adverse event

(Excluding those used for treatment of the serious adverse event)

Name of the drug: Brand/nonproprietary name	Dosage regimen	Treatment duration (MM/DD/YYYY)	Reason for use	Causal relationship	Action taken after event onset
	Dosage form/route of administration Dosage regimen	/ / to ☐ / / ☐Ongoing		☐Related ☐Not related	☐Drug withdrawn ☐Unchanged ☐Unknown ☐Dose reduced ☐Dose increased
	Dosage form/route of administration Dosage regimen	/ / to ☐ / / ☐Ongoing		☐Related ☐Not related	☐Drug withdrawn ☐Unchanged ☐Unknown ☐Dose reduced ☐Dose increased
	Dosage form/route of administration Dosage regimen	/ / to ☐ / / ☐Ongoing		☐Related ☐Not related	☐Drug withdrawn ☐Unchanged ☐Unknown ☐Dose reduced ☐Dose increased
	Dosage form/route of administration Dosage regimen	/ / to ☐ / / ☐Ongoing		☐Related ☐Not related	☐Drug withdrawn ☐Unchanged ☐Unknown ☐Dose reduced ☐Dose increased

Remarks	

Form for detailed description

Serial No.	

Information concerning readministration of medications used at time of occurrence of serious adverse event

Name of drug readministrated (Brand/nonproprietary name)	Dosage regimen	Readministration period (MM/DD/YYYY)	Onset of adverse event after readministration
		/ / to ☐ / / ☐Ongoing	☐No ☐Yes [ ]
		/ / to ☐ / / ☐Ongoing	☐No ☐Yes [ ]
		/ / to ☐ / / ☐Ongoing	☐No ☐Yes [ ]

Previous medications believed to be important in the assessment of the serious adverse event

Name of the drug (brand/nonproprietary name)	Treatment duration (MM/DD/YYYY)	Reason for use	Onset of adverse drug reaction
	/ / to / /		☐No ☐Yes [ ]
	/ / to / /		☐No ☐Yes [ ]
	/ / to / /		☐No ☐Yes [ ]

Laboratory test results believed to be related to the onset of the serious adverse event (Test slips (copies) may be provided as attachments.)

Test	Unit	Reference range		Results			
		Lower limit	Upper limit	MM/DD/YYYY / /	MM/DD/YYYY / /	MM/DD/YYYY / /	MM/DD/YYYY / /

Other laboratory test results (ECG records, X-ray images, etc. may be provided as attachments.)

Form for detailed description

Serial No.	

Clinical course: Provide an overview of the subject, including detailed time course before the onset of the serious adverse event, actions taken for the event, the outcome of the event, and other relevant information.

MM/DD/YYYY	Description
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Comments: Specify the rationale for assessment of the causal relationship with the investigational product, diagnosis of the serious adverse event, seriousness of the event, interactions between drugs used, etc.

Fatal case:

Autopsy: ☐No ☐Yes	If “yes,” specify the cause of death confirmed by autopsy:	If “no,” specify the presumed or confirmed cause of death:

Form for detailed description

Serial No.	

Information concerning the subject (parent) in case a serious adverse event affecting the offspring/fetus only

Subject identification code:	Body weight: kg Height: cm	Date of birth (MM/DD/YYYY): / / Age: XX	Predisposition of the subject (e.g., hypersensitivity) ☐No ☐Yes ( )
Sex: ☐Male ☐Female	Date of menstruation before event onset (MM/DD/YYYY): / / (Pregnancy at the start of treatment with the suspect drug: ☐No ☐Yes: XX weeks ☐Unknown)		

Underlying diseases, complicating conditions, medical history, and previous treatments believed to be related to the serious adverse event (e.g., surgical procedures, radiotherapy, blood transfusion, etc.)

	Name of disease	Date of onset (MM/DD/YYYY)	Status at the time of reporting (MM/DD/YYYY)
Underlying diseases, complicating conditions, and medical history		/ /	☐Persisting ☐Cured (/ /) ☐Unknown
		/ /	☐Persisting ☐Cured (/ /) ☐Unknown
		/ /	☐Persisting ☐Cured (/ /) ☐Unknown
		/ /	☐Persisting ☐Cured (/ /) ☐Unknown
		/ /	☐Persisting ☐Cured (/ /) ☐Unknown
		/ /	☐Persisting ☐Cured (/ /) ☐Unknown

Surgical procedures, radiotherapy, blood transfusion, etc.	Date of initiation (MM/DD/YYYY)	Status at the time of reporting (MM/DD/YYYY)
	/ /	☐Persisting ☐Cured (/ /) ☐Unknown
	/ /	☐Persisting ☐Cured (/ /) ☐Unknown
	/ /	☐Persisting ☐Cured (/ /) ☐Unknown
	/ /	☐Persisting ☐Cured (/ /) ☐Unknown

Previous medications believed to be important in the assessment of the serious adverse event

Name of the drug (Brand/nonproprietary name)	Treatment duration (MM/DD/YYYY)	Reason for use	Onset of adverse drug reaction
	/ / to / /		☐No ☐Yes [ ]
	/ / to / /		☐No ☐Yes [ ]
	/ / to / /		☐No ☐Yes [ ]

Reference Form 1

Serial No.			
Category	☐Clinical trial	☐Post-marketing clinical study	
	☐Drug	☐Medical device	☐Regenerative medical product

Date: MM/DD/YYYY

Notification of Clinical Trial-related Instructions/Decisions

To: Sponsor
(Name)
To: Investigator
(Name)

From: Head of the institution
(Name of the institution) (Title of head officer)

Regarding the review items of the clinical trial you requested, we hereby notify of our decision as follows:

Description

Chemical name or identification code of the test drug			Protocol No.	
Clinical trial title				
Description of instruction/decision	Review items (Review documents)	☐Clinical Trial Review Results Notification attached (Form 5 dated MM/DD/YYYY) As indicated in the "Review items (review documents)" field. ☐Others ( )		
	Handling	☐Approval with modifications ☐Disapproval ☐Termination of prior approval ☐Suspension		
	Condition of/reason for the "handling"			
Remarks				

Note) (Head of the institution ≠ investigator): This form should be completed by the head of the institution and then be submitted to the sponsor and the investigator.
(Head of the institution = investigator): This form should be completed by the head of the institution and then be submitted to the sponsor. The field for the investigator should be filled out as "not applicable."

Reference Form 2

Serial No.			
Category	☐Clinical trial	☐Post-marketing clinical study	
	☐Drug	☐Medical device	☐Regenerative medical product

Date: MM/DD/YYYY

Source Document Verification Application Form

To: Clinical Trial Secretariat, (Name of the institution)

From: <u>Source Document Verification Applicant</u>
(Name of the institution/department)
(Name of the applicant)

Regarding the clinical trial specified below, I hereby apply for source document verification (☐monitoring, ☐audit) as follows:

Description

Sponsor			
Chemical name or identification code of the test drug		Protocol No.	
Clinical trial title			
Desired date of source document verification	From HH:MM to HH:MM on MM/DD/YYYY		
Contact information of the person performing source document verification	TEL: FAX: E-mail:		
Witness (If applicable)	☐Investigator ☐Subinvestigator ☐Trial staff member ☐Others ( )		
Subject identification code	Documents subject to source document verification		
	☐Medical record (outpatient/inpatient) ☐Case Report Form ☐Subject diary ☐Investigational product accountability log ☐Others ( )		
	☐Medical record (outpatient/inpatient) ☐Case Report Form ☐Subject diary ☐Investigational product accountability log ☐Others ( )		
	☐Medical record (outpatient/inpatient) ☐Case Report Form ☐Subject diary ☐Investigational product accountability log ☐Others ( )		
	☐Medical record (outpatient/inpatient) ☐Case Report Form ☐Subject diary ☐Investigational product accountability log ☐Others ( )		
	☐Medical record (outpatient/inpatient) ☐Case Report Form ☐Subject diary ☐Investigational product accountability log ☐Others ( )		
Other clinical trial documents	☐Institutional Review Board meeting minutes ☐Others ( )		
Documents to be borrowed	☐Prescription drug formulary ☐Others ( )		
Remarks			

Date: MM/DD/YYYY

Confirmation Field

Message from the Clinical Trial Secretariat	☐We accept your request for source document verification as indicated above. The date and time of source document verification are: HH:MM to HH:MM on MM/DD/YYYY. ☐Others ( )	
Contact information of the person in charge of the Clinical Trial Secretariat (contact point)	Name:	Department:
	TEL:	FAX:
	E-mail:	

Note) This form should be completed by the source document verification applicant such as the sponsor (the person in charge) and then be submitted to the Clinical Trial Secretariat via FAX or E-mail. The Clinical Trial Secretariat will review the form, fill out the confirmation field, and send it via FAX or E-mail.

Precautions for completing Standard Forms

(Company-Sponsored Clinical Trials/Post-Marketing Clinical Study)

General instructions

[1] The western calendar should be used for year of the date.

[2] Serial No.: The serial number should be provided by the institution as necessary.

[3] Category (upper part): Either “clinical trial” or “post-marketing clinical study” should be selected depending on the type of investigation.

[4] Category (lower part): Either “drug”, “medical device”, or “regenerative medical product” should be selected.

[5] For Forms 1 to 11, Forms 16 to 18, and Reference Forms 1 and 2, terms should be replaced based on the selected category according to the table below. This term replacement also applies to these precautions for completing the Standard Forms.

In the form	Clinical trial		Post-marketing clinical study		
	Medical device	Regenerative medical product	Drug	Medical device	Regenerative medical product
Investigational product	Investigational device	Investigational product	Study drug	Study device	Study product
Test drug	Test device	Test product	(No term replacement required)	Test device	Test product
Clinical trial	(No term replacement required)		Post-marketing clinical study		

[6] The sponsor and the institution should discuss whether the name and seal or signature are required or not.

[7] Handling of confirmation by the department director: This item is not required by GCP, and there is not a field for confirmation by the department director in the Standard Forms. If such a confirmation is required by the institutional procedures, the Clinical Trial Secretariat may review the trial/study contract. The Clinical Trial Secretariat may also provide the department director with a duplicate copy of the document prepared by the investigator as necessary.

[8] If there is not enough space for the description in each form, an attachment (regardless of format) may be used. In this case, the field in the form should be filled out as “See the attachment.” “Regardless of format” means that it is not necessary to use a specific format as long as the required information is provided appropriately and clearly.

[9] Chemical name or identification code of the test drug: For clinical trials and post-marketing clinical studies (hereinafter referred to as “clinical trials, etc.”) of drugs, the chemical name or identification code of the test drug should be provided. For clinical trials and post-marketing clinical studies of medical devices, the name of the materials or identification code of the test device should be provided. For clinical trials and post-marketing clinical studies of regenerative medical products, the component cells, transgenes, or identification code of the test product should be provided.

[10] Duration of the clinical trial: Duration of the clinical trial specified in the protocol should be provided.

[11] Sponsor: The name of the company should be provided, or the name of the sponsor’s contract research organization may be used after discussion with the institution according to the agreement between the sponsor and the contract research organization.

[12] Contact information of the person in charge: The contact information of the person in charge on the side of the sponsor (including its contract research organization, as appropriate) should be provided. This information does not have to be changed, even if the person in charge is replaced after submission of the form. The sponsor may determine whether this information should be provided or not, as appropriate.

[13] The expression "(head of the institution ≠ investigator)" in the footnote of each form is used to specify procedures required when the head of the institution is not the investigator, and the expression "(head of the institution = investigator)" is used to specify procedures required when the head of the institution is the investigator.

[14] Name of document, attached documents: The name of a file that identifies the document may be provided. For file names, refer to "Partial Revision of Basic Principals Regarding Utilization of Electromagnetic Records in Clinical Trial-related Documents" (Administrative Notice issued on July 1, 2014 by the Evaluation and Licensing Division, Pharmaceutical and Food Safety Bureau, Ministry of Health, Labour and Welfare).

Form 1 (Curriculum Vitae)

[1] Mark "Investigator" or "Subinvestigator." For subinvestigators, curriculum vitae should be prepared if requested.

[2] Name of institution: Provide the name of the institution that the investigator/subinvestigator currently belongs to.

[3] Department/title: Provide the name of the department/title in the institution.

[4] Educational record (university): Provide the name of the university and department that the investigator/subinvestigator graduated from and the year of graduation. Information regarding graduate school is not required.

[5] License (license #): Mark "Medical doctor" and/or "Dentist," and provide the license number and the year of qualification.

[6] Qualifications for board-certified physician, etc.: Mainly information related to clinical trials etc. should be provided. It is not necessary to provide all qualifications obtained.

[7] Employment record: As an employment record of the investigator/subinvestigator for the previous approximately 5 years, the name of the institution, department, duration, and other relevant information should be provided. If there is not enough space for the description in the form, an attachment may be used. In this case, the field in the form should be filled out as "See attachment."

[8] Major research content, books/literature articles, etc.: Information related to clinical trials etc. for the previous approximately 2 years should be provided. Not more than the 10 latest publications should be provided. If there is not enough space for the description in the form, an attachment may be used. In this case, the field in the form should be filled out as "See the attachment."

[9] Experience in conducting clinical trials/post-marketing clinical studies: If there was no experience in the previous approximately 2 years, enter "0" in this field. If the investigator/subinvestigator had earlier experience in conducting clinical trials/post-marketing clinical studies, briefly describe in the field for remarks the trials/studies that he/she has been involved in.

[10] Experience in conducting clinical trials/post-marketing clinical studies: No. of trials/studies: Provide the total number of clinical trials and post-marketing clinical studies that the investigator/subinvestigator has been involved in as an investigator/subinvestigator in the previous approximately 2 years as well as the number of ongoing trials/studies (the number of protocols) that the investigator/subinvestigator is currently involved in by drug, medical device, and regenerative medical product. Concerning the number of trials/studies, provide the number of trials/studies in which the investigator/subinvestigator has served as an investigator/subinvestigator, regardless of whether he/she has successfully enrolled subjects.

[11] Remarks: Provide any information worth noting.

[12] It is not necessary to fill out all the fields if it is shown in the form that the investigator/subinvestigator is capable of conducting the clinical trial or performing assigned duties and functions in an appropriate manner.

[13] If any changes occur in the information provided in the form during the clinical trial, it is not necessary to update or re-submit the form, as long as the changes will not affect the trial organization (e.g., department/title, name, and experience in conducting clinical trials/post-marketing clinical studies).

Form 2 (List of Subinvestigator(s) and Clinical Trial Staff Members)

[1] Mark either "New" or "Change." If only the department or title changes, it is not necessary to complete this form.

[2] Brief description of duties to be shared: Mark either "General clinical trial duties and functions" or "General clinical trial assistant duties and functions." If the subinvestigator is clearly responsible for a certain duty and function, or the clinical trial staff member is not a subinvestigator, mark the checkbox on the right before the parentheses and specify the duty and function in the parentheses. This also applies when general duties and functions are specified in detail. If there is not enough space for the description, an attachment may be used. In this case, the parentheses should be filled out as "See the attachment."

[3] Department or title: Department or title should be provided if required by the institution.

[4] According to GCP, Form 2 is not subject to review by the institutional review board. It should be noted, however, that a document providing the name of the individual who will serve as a subinvestigator is subject to review.

Form 3 (Clinical Trial Request Form)

[1] Clinical trial title: Enter the clinical trial title in the upper part of this section. Enter the agenda (title) used for the outline of the institutional review board meeting minutes prepared by the individual who founded the institutional review board in the lower part of this section. If the sponsor rather wishes to use a different title from the clinical trial title, follow Clause 2-6-2, Article 28 of the GCP Guidance for Drugs or Clause 2-6-2, Article 47 of the GCP Guidance for Medical Devices. This also applies to regenerative medical products.

[2] List of Attached Documents: The name of each attachment should be marked. Provide specific names for these documents as well as the date of preparation and the version number necessary to identify each document (it is not necessary to provide both the date of preparation and the version number if the document can be identified). For example, the date of preparation and the version number are usually provided for a protocol, because it is revised as necessary. "None" should be entered in the field for version number. For other documents that can be identified by their names (e.g., documents concerning the anticipated clinical trial expenses, etc.)

[3] List of Attached Documents: Investigator's Brochure or package insert: The name of the Investigator's Brochure for the investigational product or other equivalent documents should be provided for clinical trials of drugs. The name of the Investigator's Brochure for the investigational device or other equivalent documents should be provided for clinical trials of medical devices. The name of the Investigator's Brochure for the investigational product or other equivalent documents should be provided for clinical trials of regenerative medical products. The name of the package insert or other equivalent documents

should be provided for post-marketing clinical studies.

[4] List of Attached Documents: A list of prospective subinvestigators (Name List) may be used in place of the "List of Subinvestigators and Clinical Trial Staff Members" (Form 2).

[5] List of Attached Documents: Others: Provide the name of attached documents, including documents provided to subjects (e.g., subject diary), the document regarding the scope of duties and functions of the contract research organization, the document regarding other drugs with similar pharmacological effects and/or indications (for drugs), and the document regarding a similar medical device (for medical devices).

Form 4 (Clinical Trial Review Request Form)

[1] Review items (Attached documents): Mark each applicable item. If there are additional items, mark "Others" and provide a brief description.

[2] If the sponsor simultaneously submits the "Safety Information Report" (Form 16) to the institutional review board in addition to the investigator and the head of the institution, it may be regarded that the head of the institution has provided the institutional review board with the necessary written information related to the "Safety Information Report" (Form 16), and it is therefore not necessary to prepare Form 4.

Form 5 (Clinical Trial Review Results Notification)

[1] Review items (Review documents): Mark each applicable item, and provide the date of the reviewed documents.

[2] Category of review: date of review: Provide the date of the institutional review board meeting. Date of the completion of review: Provide the date of the completion of expedited review.

[3] Review result: Mark each applicable item. If more than one item is reviewed and the review results differ across the review items, a notification may be issued for each review result, or different review results may separately be provided in the same notification as appropriate.

[4] Member categories: The category of each member should be described using the following category numbers:

(1) Members whose primary area of interest is in a nonscientific area

(2) Members who are independent of the institution (excluding members falling under category (1))

(3) Members who are independent of the founder of the institutional review board (excluding members falling under category (1))

(4) Members who are not classified as category (1), (2), or (3)

[5] Attendances/absences: Members who attended the meeting and are not involved in the clinical trial should be marked as "○", members who attended the meeting but did not participate in the review or voting due to involvement in the clinical trial should be marked as "–", and members who were absent from the meeting should be marked as "×".

[6] In cases involving expedited review, provide the names of the members who performed the review in the List of Attendees/Absentees of the Institutional Review Board Members. If the number of members is small, provide the required information, including the names of the members, in the "Remarks" field on the first page.

[7] The first and second pages are a set of documents, and the same date of preparation should therefore be provided.

[8] Remarks (first page): The “Remarks” field should be filled out only if there are additional comments to be made (e.g., approved but with comments).

[9] Remarks (second page): The “Remarks” field should be filled out only if there are additional comments to be made (e.g., the name of the chairperson is required).

[10] If the sponsor simultaneously submits the “Safety Information Report” (Form 16) to the institutional review board in addition to the investigator and the head of the institution, the institutional review board may use Form 5 to provide an opinion only on the appropriateness of continuing the clinical trial in relation to the “Safety Information Report” (Form 16) to the investigator and the sponsor in addition to the head of the institution. In this case, it may be regarded that the head of the institution has provided the necessary information to the sponsor and the investigator.

[11] If an agreement is made regarding the procedure specified in [10] above, and approval is obtained from the sponsor, the institutional review board, and the head of the institution, the name of the investigator may be described as “each investigator,” and the name of the institution and the title of the head officer of the institution may be described as “the head of each institution.”

[12] If the decision made by the institutional review board is consistent with the instruction given by the head of the institution, the field below the table in Form 5 may be used. If these are not consistent, the “Notification of Clinical Trial-related Instructions/Decisions” (Reference Form 1) should be used.

Form 6 (Protocol Modification Report)

[1] Condition/reason etc. for “approval with modifications”: Enter the information provided in the field for the reason for not being “approval” in the “Clinical Trial Review Results Notification” (Form 5) (if the decision made by the institutional review board is consistent with the instructions given by the head of the institution) or in the applicable field in the “Notification of Clinical Trial-related Instructions/Decisions” (Reference Form 1) (if the decision made by the institutional review board is not consistent with the instructions given by the head of the institution).

[2] Depending on the actions taken (e.g., revision of the written information for subjects and informed consent form), the form may be completed by the investigator, and the field for the sponsor is filled out as “not applicable.”

[3] Action taken: Provide a specific but brief description of the action taken (including the necessary information to identify the amended protocol to be attached as appropriate [date of preparation and/or version number]).

[4] If the head of the institution confirms that the instruction provided in the field for the condition/reason for “Approval with modifications” has been appropriately followed, there is usually no need to reconsider it at an institutional review board meeting. For handling, the standard operating procedures of each institution should be followed.

Form 8 (Report concerning Protocol Deviations to Eliminate Immediate Hazards)

[1] Reason for the deviation: In addition to the reason for the deviation, provide a specific but brief description of the actions taken against the deviation and the preventive actions. If a document is attached as appropriate, the necessary information to identify the document (e.g., name of the document, date of preparation, and version number) should also be provided.

[2] According to GCP, other deviations than those reported in Form 8 should be recorded by the investigator

or the subinvestigator. Such a record may be confirmed by the medical record or other equivalent documents, and it is not necessary to prepare a separate specific document for these records.

Form 9 (Notification of Protocol Deviations to Eliminate Immediate Hazards)

[1] Review result: Mark each applicable item.

[2] Reason, etc. if not agreed: If "Not agreed" is marked in the field for the review result, the reason for it should be detailed. If a protocol amendment is proposed by the investigator, the actions to be taken should be specified.

Form 10 (Clinical Trial-related Change Application Form)

[1] Document, etc. subject to the change:

- Mark each applicable item.
- If the addition or removal of subinvestigators affects the trial organization, application for changes using Form 10 will be required. It is not necessary to apply for changes in case of changes that do not affect the trial organization (change of department/title or name).

[2] Depending on the change (e.g., a change to the written information for subjects and informed consent form), the investigator may complete the form, and fill out the field for the sponsor as "not applicable."

[3] Description of the change: Provide a specific but brief description of the change.

[4] Attached documents: Provide the necessary information to identify the attached document (e.g., name of the document, date of preparation, and version number).

Form 11 (Clinical Trial Progress Report)

[1] No. of subjects enrolled in the trial: For clinical trials of drugs, the number of subjects receiving the investigational product should be provided. For clinical trials of medical devices, the number of subjects using the investigational device should be provided. For clinical trials of regenerative medical products, the number of subjects using the investigational product should be provided. If cell or tissue samples were collected to manufacture the investigational product, these subjects should also be included. In addition, the number of subjects who received the investigational product/used the investigational device or investigational product and completed or discontinued the trial should be provided in the parentheses. If an additional explanation is necessary regarding the number of subjects enrolled in the trial, it should be provided in the "Others" field in the "Progress of the clinical trial" section.

[2] Progress of the clinical trial: A brief description of safety and compliance with GCP should mainly be provided. In the absence of serious adverse events and protocol deviations worth mentioning, the number of subjects with adverse events and safety assessment, the number of protocol deviation to eliminate immediate hazards, and results of GCP compliance assessment should typically be provided in short form.

Serious Adverse Event Report

[1] Form 12 should be used for clinical trials of drugs.

[2] Form 13 should be used for post-marketing clinical studies of drugs.

[3] Form 14 should be used for clinical trials of medical devices.

[4] Form 15 should be used for post-marketing clinical studies of medical devices.

[5] Form 19 should be used for clinical trials of regenerative medical products.

[6] Form 20 should be used for post-marketing clinical studies of regenerative medical products.

[7] In all cases of [1] to [6] above, an applicable form for detailed description should be used to report the status of the subject who has experienced a serious adverse event. If approved by the institution and the sponsor (and the institutional review board, as appropriate), other forms may be used.

[8] If more than one serious adverse event or malfunction that may cause a serious adverse event is observed, a separate form should be prepared for each event/malfunction.

[9] For trials of combination products, forms to be used should be defined in advance based on the agreement between the sponsor, the institutional review board, and the institution. If there is not a particular reason, the table below should be followed. The term "malfunction" in the table refers to a malfunction that may cause a serious adverse event (including the case that an adverse event has actually occurred).

[10] For post-marketing clinical studies, Forms 12, 14, and 19 in the table below should be replaced by Forms 13, 15, and 20, respectively.

<When the investigational product/device is used alone (i.e., it is not a study of a combination product)>

Drug	Medical device	Regenerative medical product	Serious Adverse Event	Malfunction	Form 12	Form 14	Form 19	Form for detailed description
○			Yes	Not applicable	Required			Required
	○		Yes	No		Required		Required
	○		Yes	Yes		Required		Required
	○		No	Yes		Required		Not required
		○	Yes	No			Required	Required
		○	Yes	Yes			Required	Required
		○	No	Yes			Required	Not required

<In case of a study of a combination product>

Drug	Medical device	Regenerative medical product	Serious Adverse Event	Malfunction	Form 12	Form 14	Form 19	Form for detailed description
○	○		Yes	No	Required	Required		Required
○	○		Yes	Yes	Required	Required		Required
○	○		No	Yes	Required	Required		Not required
○		○	Yes	No	Required		Required	Required
○		○	Yes	Yes	Required		Required	Required
○		○	No	Yes	Required		Required	Not required
	○	○	Yes	No		Required	Required	Required
	○	○	Yes	Yes (Device/ Regenerative)		Required	Required	Required
	○	○	No	Yes (Device/ Regenerative)		Required	Required	Not required
○	○	○	Yes	No	Required	Required	Required	Required
○	○	○	Yes	Yes (Device/ Regenerative)	Required	Required	Required	Required
○	○	○	No	Yes (Device/ Regenerative)	Required	Required	Required	Not required

If updated information is obtained, a follow-up report should only be prepared for applicable forms.

Form 12 (Serious Adverse Event Report [For Clinical Trials of Drugs])

Form 13 (Serious Adverse Event Report [For Post-Marketing Clinical Studies of Drugs])

[1] Title: Clarify how many times the adverse event has been reported.

[2] Information concerning the individual experiencing the serious adverse event: Either the date of birth (year only or month and year only are also acceptable) or age should be provided based on the information provided in the Case Report Form for the clinical trial. The date of menstruation before the onset of the serious adverse event should be provided if required.

[3] Information concerning the serious adverse event: The availability of detailed information should be selected. If "Yes," mark either "Standard Forms" or "Other forms," depending on which type of forms is used; the designated form for the detailed description (Standard Forms) or non-designated forms (other forms) (see above-mentioned [7] for "Serious Adverse Event Report"). Mark "No" if detailed information is not available because it is the initial report.

[4] Information concerning the serious adverse event: Expectedness of event with respect to the investigational product: The expectedness should be assessed based on information provided in the Investigator's Brochure (or package insert). If the event is consistent with information provided in the Investigator's Brochure (or package insert) in terms of the nature and severity, the event should be considered as "expected." If the event is not consistent with information provided in the Investigator's Brochure (or package insert) in terms of the nature and severity (e.g., acute renal failure vs "interstitial nephritis" and hepatitis vs "fulminant hepatitis"), the event should be considered "unexpected."

[5] Information concerning the serious adverse event: Date of event onset: Provide the date of onset of the reported adverse event.

[6] Information concerning the serious adverse event: Reason why event was determined to be serious: Provide the date when the reported event was determined to be serious, and mark the applicable reason. More than one reason may be selected.

[7] Information concerning the investigational product: Investigational product: For blinded treatment, mark "Test product (blinded)." For the test drug, mark "Test product." For the comparator, mark "Others." Provide the name of the drug if known.

[8] Causal relationship with the event: Assess the causal relationship according to Article 2-15 (10) of the GCP Guidance for Drugs.

[9] Information concerning the investigational product: Action taken after event onset: If treatment with the investigational product has already been completed at event onset, mark "Not applicable."

[10] Remarks: For studies of combination products, it should be clarified that there are other report forms related to this report. These report forms are identified by the type of form, subject identification code, serious adverse event term, malfunction term, number of reports, and date of report.

Form 14 (Serious Adverse Event and Malfunction Report [For Clinical Trials of Medical Devices])

Form 15 (Serious Adverse Event and Malfunction Report [For Post-Marketing Clinical Studies of Medical Devices])

[1] Title: Clarify how many times the adverse event has been reported.

[2] Depending on whether it is a serious adverse event or a malfunction that may cause a serious adverse event (including the case that an adverse event has actually occurred), mark either as applicable according to the table below:

<table>
<tr><td>Serious adverse event</td><td>Yes</td><td>Yes</td><td>No</td></tr>
<tr><td>Malfunction*</td><td>Yes</td><td>No</td><td>Yes</td></tr>
<tr><td rowspan="2">Check of the first sentence</td><td>■Adverse event determined to be serious</td><td>■Adverse event determined to be serious</td><td>☐Adverse event determined to be serious</td></tr>
<tr><td>■Malfunction that may cause a serious adverse event</td><td>☐Malfunction that may cause a serious adverse event</td><td>■Malfunction that may cause a serious adverse event</td></tr>
<tr><td>Information concerning the individual experiencing the serious adverse event, etc.</td><td colspan="3">Note: Fill out according to precautions [3] to [4] to complete Forms 14 and 15.</td></tr>
<tr><td rowspan="4">Information concerning the serious adverse event
Check of the availability of detailed information</td><td colspan="2">If no detailed information is available because it is the initial report:
☐Available (☐Standard Forms ☐Other forms) ■Not available ☐Not applicable</td><td rowspan="4">☐Yes (☐Standard Form ☐Other forms)
☐No
■Not applicable

Note: Do not fill out this field.</td></tr>
<tr><td colspan="2">If detailed information is available: The designated form for detailed description is used.
■Available (■Standard Forms ☐Other forms) ☐Not available ☐Not applicable</td></tr>
<tr><td colspan="2">If detailed information is available: Non-designated forms are used.
■Available (☐Standard Forms ■Other forms) ☐Not available ☐Not applicable</td></tr>
<tr><td colspan="2">Note: Fill out according to precautions [5] to [7] to complete Forms 14 and 15.</td></tr>
<tr><td>Information concerning the investigational device (including procedures)</td><td colspan="3">Note: Fill out according to precautions [8] to [11] to complete Forms 14 and 15.</td></tr>
<tr><td>Causal relationship with the event</td><td colspan="2">(Assess the causal relationship without selecting “Not applicable.”)</td><td>■Not applicable</td></tr>
<tr><td>Action taken against the event caused by the investigational device</td><td colspan="2">(Check whether action was taken)</td><td>■Not applicable</td></tr>
<tr><td>Check of information concerning the investigational device malfunction</td><td>☐Not applicable
Note: Fill out according to precautions [12] to [14] to complete Forms 14 and 15.</td><td>■Not applicable
Note: Do not fill out this field.</td><td>☐Not applicable
Note: Fill out according to precautions [12] to [14] to complete Forms 14 and 15.</td></tr>
</table>

*: The term “malfunction” refers to a malfunction that may cause a serious adverse event (including the case that an adverse event has actually occurred).

[3] Information concerning the individual experiencing the serious adverse event, etc.: Either the date of birth (year only or month and year only are also acceptable) or age should be provided based on the information provided in the Case Report Form for the clinical trial. The date of menstruation before the onset of the serious adverse event should be provided if required.

[4] If the subject cannot be identified because the device malfunction has occurred before the investigational device has been used, the field for the subject identification code should be filled out as “not applicable,” mark “Others” in the field for the category of the individual experiencing the serious adverse event in the section of information concerning the individual experiencing the serious adverse event, etc. and specify as “not applicable.”

[5] Information concerning the serious adverse event: Expectedness of event with respect to the investigational device: The expectedness should be assessed based on information provided in the Investigator’s Brochure (or package insert). If the event is consistent with information provided in the Investigator’s Brochure (or package insert) in terms of the nature and severity, the event should be considered as “expected.” If the event is not consistent with information provided in the Investigator’s Brochure (or package insert) in terms of the nature and severity (e.g., acute renal failure vs “interstitial nephritis” and hepatitis vs “fulminant hepatitis”), the event should be considered “unexpected.”

[6] Information concerning the serious adverse event: Date of event onset: Provide the date of onset of the reported adverse event.

[7] Information concerning the serious adverse event: Reason why event was determined to be serious:

Provide the date when the reported event was determined to be serious, and mark the applicable reason. More than one reason may be selected.

[8] Information concerning the investigational device (including procedures): Investigational device, etc.: For blinded treatment, mark “Test device (blinded).” For the test device, mark “Test device.” For the comparator or accessories, mark “Others.” As for the status of blinding, additional information should be provided in the “Description of the investigational device malfunction” or “Remarks” field in the “Information concerning the investigational device malfunction” section. As for the lot number, the lot or serial number of the investigational device should be provided.

[9] Information concerning the investigational device (including procedures): Date/duration of use: For a procedure, the date of completion should be provided. For the investigational device, the duration of use should be provided. If completed, mark the field for the date to enter the specific date. If currently performed or used, mark the applicable one without entering the date. If the investigational device has not been removed from the subject’s body, mark “Currently in use.” If the malfunction has occurred at a time when the procedure was not performed or the device was not used, it is not necessary to enter the date. If additional information concerning the investigational device is required, specify it in the “Description of the investigational device malfunction” or the “Remarks” field in the “Information concerning the investigational device malfunction” section.

[10] Information concerning the investigational device (including procedures): Causal relationship with the event: Regarding the causal relationship between the adverse event and the procedure/investigational device, mark the applicable one. If there are no adverse events to be reported or no procedures were performed, mark “Not applicable.”

[11] Information concerning the investigational device (including procedures): Action taken against the event caused by the investigational device: Regarding action taken after the onset of the adverse event, mark “Yes” or “No.” Detailed information concerning the action taken should be provided in the “Information concerning the investigational device malfunction” section. If there are no adverse events to be reported or no procedures were performed, mark “Not applicable.”

[12] Information concerning the investigational device malfunction: Provide information concerning the investigational device malfunction. If there are no malfunctions, mark “Not applicable.”

[13] Information concerning the investigational device malfunction: Date of onset of the investigational device malfunction: In field for the “date of onset of the investigational device malfunction,” the time should also be entered as appropriate.

[14] Information concerning the investigational device malfunction: Possible cause of the investigational device malfunction: Select the presence or absence of the cause in the applicable field. If “Yes,” specify.

[15] Reason for considering that the investigational device malfunction may cause a serious adverse event: This field should be filled out regardless of the presence or absence of a serious adverse event.

[16] Remarks: For clinical trials of combination products, it should be clarified that there are other report forms related to this report. These report forms are identified by the type of form, subject identification code, serious adverse event term, malfunction term, number of reports, and date of report. Other comments, if any, should also be provided.

Form 16 (Safety Information Report)

[1] Outline of the safety information (upper part): If an individual case report concerning an unexpected

adverse drug reaction is submitted, mark all applicable items.

[2] Outline of the safety information (lower part): If an annual report, a research report, or a safety measure report is submitted, mark all applicable items.

[3] For annual reports on drugs, Attached Form 1 (Development Safety Update Report Summary) and Attached Form 2 (List of Serious Adverse Drug Reactions in Japan) defined in "Considerations for Enforcement of the Ministerial Ordinance on Partial Amendments to the Enforcement Regulations of Pharmaceutical Affairs Law" (PFSB/ELD Notification No. 1228-11 issued by the Director of the Evaluation and Licensing Division, Pharmaceutical and Food Safety Bureau, Ministry of Health, Labour and Welfare on December 28, 2012) should be attached.

[4] Sponsor's opinion: Mark each applicable item.

[5] Attached documents: Provide the necessary information to identify an attached document (e.g., name of the document, date of preparation, and version number).

[6] Remarks: The investigator's opinion and comments and other related information may be provided as necessary. If there is not enough space for the description, an attachment may be used. In this case, the field in the form should be filled out as "Concerning the investigator's opinion, see the attachment."

[7] If approval is obtained from both the sponsor and the institution, the name of the institution and the title of the head officer of the institution may be described as "the head of each institution," and the name of the investigator may be described as "each investigator."

[8] If agreed in advance between the sponsor, the institutional review board, and the head of the institution, the sponsor may simultaneously submit the form to the institutional review board, in addition to the investigator and the head of the institution. In this case, it may be regarded that the head of the institution has provided the institutional review board with the necessary written information, and it is therefore not necessary to prepare Form 4.

[9] If an agreement is made regarding the procedure specified in [8] above, and approval is obtained from the sponsor, the institutional review board and the head of the institution, the name of the institutional review board may be described as "each institutional review board."

[10] If approval is obtained from the sponsor, the investigator, the institutional review board, and the head of the institution, Form 16 may be replaced by the reference form (Annual Report of Clinical Trial Safety Information) defined in "Considerations for Enforcement of Ministerial Ordinance on Partial Amendments to the Enforcement Regulations of the Pharmaceutical Affairs Law" (PFSB/ELD Notification No. 1228-11 issued by the Director of the Evaluation and Licensing Division, Pharmaceutical and Food Safety Bureau, Ministry of Health, Labour and Welfare on December 28, 2012).

Form 17 (Clinical Trial Completion [Premature Termination/Suspension] Report)

[1] Checkboxes for "Completed," "Premature Terminated," and "Suspended": Mark each applicable item.

[2] No. of subjects enrolled in the trial: For clinical trials of drugs, the number of subjects receiving the investigational product should be provided. For clinical trials of medical devices, the number of subjects using the investigational device should be provided. For clinical trials of regenerative medical products, the number of subjects using the investigational product should be provided. If cell or tissue samples were collected to manufacture the investigational product, these subjects should also be included. If an additional explanation is necessary regarding the number of subjects enrolled in the trial, it should be provided in the "Others" field in the "Overview of clinical trial results, etc." section.

[3] Overview of clinical trial results, etc.: If there is not enough space for the description, an attachment may be used. In this case, the field in the form should be filled out as “See the attachment.”

Form 18 (Development Discontinuation Report)

[1] In case of “Obtainment of marketing approval” or “Notification of results of reexamination/reevaluation” in the “Information reported” section, the reportability to the institutional review board will be determined by discussion between the head of the institution and the institutional review board.

[2] Document retention, etc.: Mark the applicable item, and provide the necessary information.

[3] If approval is obtained from both the sponsor and the institution, the name of the institution and the title of the head officer of the institution may be described as “the head of each institution,” and the name of the investigator may be described as “each investigator.”

Form 19 (Serious Adverse Event and Malfunction Report [For Clinical Trials of Regenerative Medical Products])

Form 20 (Serious Adverse Event and Malfunction Report [For Post-Marketing Clinical Studies of Regenerative Medical Products])

[1] Title: Clarify how many times the adverse event has been reported.

[2] Depending on whether it is a serious adverse event or a malfunction that may cause a serious adverse event (including the case that an adverse event has actually occurred), provide either applicable one according to the table below:

<table>
<tr><td>Serious adverse event</td><td>Yes</td><td>Yes</td><td>No</td></tr>
<tr><td>Malfunction*</td><td>Yes</td><td>No</td><td>Yes</td></tr>
<tr><td rowspan="2">Check of the first sentence</td><td>■Adverse event determined to be serious</td><td>■Adverse event determined to be serious</td><td>☐Adverse event determined to be serious</td></tr>
<tr><td>■Malfunction that may cause a serious adverse event</td><td>☐Malfunction that may cause a serious adverse event</td><td>■Malfunction that may cause a serious adverse event</td></tr>
<tr><td>Information concerning the individual experiencing the serious adverse event, etc.</td><td colspan="3">Note: Fill out according to precautions [3] to [4] to complete Forms 19 and 20.</td></tr>
<tr><td rowspan="4">Information concerning the serious adverse event Check of the availability of detailed information</td><td colspan="2">If no detailed information is available because it is the initial report:
☐Available (☐Standard Forms ☐Other forms) ■Not available ☐Not applicable</td><td rowspan="4">☐Yes (☐Standard Form ☐Other forms)
☐No
■Not applicable

Note: Do not fill out this field.</td></tr>
<tr><td colspan="2">If detailed information is available: The designated form for detailed description is used.
■Available (■Standard Forms ☐Other forms) ☐Not available ☐Not applicable</td></tr>
<tr><td colspan="2">If detailed information is available: Non-designated forms are used.
■Available (☐Standard Forms ■Other forms) ☐Not available ☐Not applicable</td></tr>
<tr><td colspan="2">Note: Fill out according to precautions [5] to [7] to complete Forms 19 and 20.</td></tr>
<tr><td>Information concerning the investigational product (including procedures)</td><td colspan="3">Note: Fill out according to precautions [8] to [11] to complete Forms 19 and 20.</td></tr>
<tr><td>Causal relationship with the event</td><td colspan="2">(Assess the causal relationship without selecting “Not applicable.”)</td><td>■Not applicable</td></tr>
<tr><td>Action taken against the event caused by the investigational product</td><td colspan="2">(Check whether action was taken or not.)</td><td>■Not applicable</td></tr>
<tr><td>Check of information concerning the investigational product malfunction</td><td>☐Not applicable
Note: Fill out according to precautions [12] to [14] to complete Forms 19 and 20.</td><td>■Not applicable
Note: Do not fill out this field.</td><td>☐Not applicable
Note: Fill out according to precautions [12] to [14] to complete Forms 19 and 20.</td></tr>
</table>

*: The term “malfunction” refers to a malfunction that may cause a serious adverse event (including the case that an adverse event has actually occurred).

[3] Information concerning the individual experiencing the serious adverse event, etc.: Either the date of birth (year only or month and year only are also acceptable) or age should be provided based on the information provided in the Case Report Form for the clinical trial. The date of menstruation before the onset of the serious adverse event should be provided if required.

[4] If the subject cannot be identified because the product malfunction has occurred before the investigational product has been used, the field for the subject identification code should be filled out as “not applicable,” mark “Others” in the field for the category of the individual experiencing the serious adverse event in the section of information concerning the individual experiencing the serious adverse event, etc. and specify as “not applicable.”

[5] Information concerning the serious adverse event: Expectedness of event with respect to the investigational product: The expectedness should be assessed based on information provided in the Investigator’s Brochure (or package insert). If the event is consistent with information provided in the Investigator’s Brochure (or package insert) in terms of the nature and severity, the event should be considered as “expected.” If the event is not consistent with information provided in the Investigator’s Brochure (or package insert) in terms of the nature and severity (e.g., acute renal failure vs “interstitial nephritis” and hepatitis vs “fulminant hepatitis”), the event should be considered “unexpected.”

[6] Information concerning the serious adverse event: Date of event onset: Provide the date of onset of the reported adverse event.

[7] Information concerning the serious adverse event: Reason why event was determined to be serious: Provide the date when the reported event was determined to be serious, and mark the applicable reason. More than one reason may be selected.

[8] Information concerning the investigational product (including procedures): Investigational product, etc.: For blinded treatment, mark “Test product (blinded).” For the test product, mark “Test product.” For the comparator or accessories, mark “Others.” As for the status of blinding, additional information should be provided in the “Description of the investigational product malfunction” or “Remarks” field in the “Information concerning the investigational product malfunction” section. As for the lot number, the lot or serial number of the investigational product should be provided.

[9] Information concerning the investigational product (including procedures): Date/duration of use: For a procedure, the date of completion should be provided. For the investigational product, the duration of use should be provided. If completed, mark the field for the date to enter the specific date. If currently performed or used, mark the applicable one without entering the date. If the investigational product has not been removed from the subject’s body, mark “Currently in use.” If the malfunction has occurred at a time when the procedure was not performed or the product was not used, it is not necessary to enter the date. If additional information concerning the investigational product is required, specify it in the “Description of the investigational product malfunction” or the “Remarks” field in the “Information concerning the investigational product malfunction” section.

[10] Information concerning the investigational product (including procedures): Causal relationship with the event: Regarding the causal relationship between the adverse event and the procedure/investigational product, mark the applicable one. If there are no adverse events to be reported or no procedures were performed, mark “Not applicable.”

[11] Information concerning the investigational product (including procedures): Action taken against the event caused by the investigational product: Regarding action taken after the onset of the adverse event, mark “Yes” or “No.” Detailed information concerning the action taken should be provided in the “Information concerning the investigational product malfunction” section. If there are no adverse events to be reported or no procedures were performed, mark “Not applicable.”

[12] Information concerning the investigational product malfunction: Provide information concerning the investigational product malfunction. If there are no malfunctions, mark “Not applicable.”

[13] Information concerning the investigational product malfunction: Date of onset of the investigational product malfunction: In field for the “date of onset of the investigational product malfunction,” the time should also be entered as appropriate.

[14] Information concerning the investigational product malfunction: Possible cause of the investigational product malfunction: Select the presence or absence of the cause in the applicable field. If “Yes,” specify.

[15] Reason for considering that the investigational product malfunction may cause a serious adverse event: This field should be filled out regardless of the presence or absence of a serious adverse event.

[16] Remarks: For studies of combination products, it should be clarified that there are other report forms related to this report. These report forms are identified by the type of form, subject identification code, serious adverse event term, malfunction term, number of reports, and date of report. Other comments, if any, should also be provided.

Form for detailed description (Attachment forms common to Forms 12 to 15 and Forms 19 to 20)

[1] In the event of a serious adverse event, these forms should be attached to Forms 12 to 15 and Forms 19 to 20. These forms may be replaced by other forms. In this case, the institution and the sponsor should discuss to decide on the forms. The institutional review board will also participate in the discussion and decision-making as necessary.

[2] Medications used at the onset of the serious adverse event: If the dosage regimen is changed, the duration of treatment should be clarified (new fields may be used).

[3] Clinical course: Enter the date of onset of the reported adverse event, the date when it was determined to be serious, and the outcome of the event, and clearly provide the duration of the event. If treatment is blinded, the status of unblinding should be provided in addition to the information required in each field.

[4] If a serious adverse event occurs only in an offspring/ fetus, information concerning the subject (parent) should be provided. If a serious adverse event occurs in the subject, page 4 of the form does not have to be completed.

Reference Form 1 (Notification of Clinical Trial-related Instructions/Decisions)

[1] Reference Form 1 should be used if the decision made by the institutional review board is not consistent with the instructions given by the head of the institution in the "Clinical Trial Review Results Notification" (Form 5).

[2] Review items (Review documents): Mark each applicable item.

[3] Handling: Mark the applicable item.

[4] Condition of/reason for the "handling": Provide a specific but brief description.

Reference Form 2 (Source Document Verification Application Form)

[1] Generally, it should be made clear that source document verification is performed according to the contract, and therefore, a specific form does not have to be submitted each time source document verification is performed. However, a certain form of guarantee is necessary to avoid misunderstanding of the date of source document verification and other related information. When such a guarantee is provided in writing, Reference Form 2 should be used. Since Reference Form 2 is handled between individuals who are directly involved in source document verification, the addressee of the form is the institution's secretariat, and the sender of the form is the individual to perform the source document verification (or a representative if there is more than one individual performing source document verification). The GCP specifies that results of source document verification should be appropriately provided to the investigator/subinvestigator if there is a particular reason to do so (e.g., protocol deviations). However, the GCP does not require the individual performing source document verification to report in writing results of source document verification to the institution every time source document verification is performed. Reference Form 2 is not subject to review or reporting by the institutional review board.

[2] Contact information of the person performing source document verification: If more than one individual visits the institution for source document verification, information of a representative (the source document verification applicant) should be provided. If the institution needs to know in advance who will perform source document verification for any particular reason (e.g., direct access to electronic medical charts), information concerning all individuals to be involved in source document verification (the

necessary information, such as name and department) should be provided in the “Remarks” field. Although the form has fields for phone and fax numbers and E-mail address as the means of communication, only the one actually used as the means of communication with the institution should be filled out.

[3] Witness (If applicable): Mark each applicable item. If “Subinvestigator,” “Trial staff member,” or “Others” is marked, the necessary information to identify the witness (e.g., name) should be provided in the “Remarks” field.

[4] Subject identification code: If the document subject to source document verification is the same, more than one code or a range of codes (e.g., XX-1 to XX-20) should be provided in the single field.

[5] Contact information of the person in charge of the Clinical Trial Secretariat (contact point): Although the form has fields for phone and fax numbers and E-mail address as the means of communication, only the one actually used as the means of communication with the individual performing the source document verification should be filled out.

List of Standard Forms

(For Investigator-initiated Clinical Trials)

Standard Form No.	Name of document
(Investigator) Form 1	Curriculum Vitae
(Investigator) Form 2	List of Subinvestigator(s) and Clinical Trial Staff Members
(Investigator) Form 3	Clinical Trial Application Form
(Investigator) Form 4	Clinical Trial Review Request Form
(Investigator) Form 5	Clinical Trial Review Results Notification
(Investigator) Form 6	Protocol Modification Report
(Investigator) Form 7	[This form number is not used.]
(Investigator) Form 8	Report concerning Protocol Deviations to Eliminate Immediate Hazards
(Investigator) Form 9	[This form number is not used.]
(Investigator) Form 10	Clinical Trial-related Change Application Form
(Investigator) Form 11	Clinical Trial Progress Report
(Investigator) Form 12	Serious Adverse Event Report (For Clinical Trials of Drugs)
(Investigator) Form 13	[This form number is not used.]
(Investigator) Form 14	Serious Adverse Event and Malfunction Report (For Clinical Trials of Medical Devices)
(Investigator) Form 15	[This form number is not used.]
(Investigator) Form 16	Safety Information Report
(Investigator) Form 17	Clinical Trial Completion (Premature Termination/Suspension) Report
(Investigator) Form 18	Development Discontinuation Report
(Investigator) Form 19	Serious Adverse Event and Malfunction Report (For Clinical Trials of Regenerative Medical Products)
(Investigator) Form 20	[This form number is not used.]
(Investigator) Form for detailed description	(For detailed description of Forms 12, 14, and 19)
(Investigator) Reference Form 1	Notification of Clinical Trial-related Instructions/Decisions
(Investigator) Reference Form 2	Source Document Verification Application Form

(Investigator) Form 1

Serial No.	

Date: MM/DD/YYYY

Curriculum Vitae

(☐Investigator ☐Subinvestigator)

Japanese syllabaries				
Name				
Name of institution				
Department/title				
Educational record (university)	Name of university	Name of department	Year of graduation	YYYY
License	☐Medical doctor, license # ( ) Year of qualification (YYYY) ☐Dentist, license # ( ) Year of qualification (YYYY)			
Qualifications for board-certified physician, etc.				
Employment record (For the previous approx. 5 years)	From MM/YYYY to MM/YYYY : From MM/YYYY to MM/YYYY : From MM/YYYY to MM/YYYY : From MM/YYYY to MM/YYYY : From MM/YYYY to date :			
Specialty				
Affiliated academic societies, etc.				
Major research content, books/literature articles, etc. (Not more than the latest 10 publications related to clinical trial)				
Experience in conducting clinical trials/post-marketing clinical studies (For the previous approx. 2 years)	Trial/study category	Drug	Medical device	Regenerative medical product
	No. of trials/studies (No. of ongoing trials/studies)	XX (YY)	XX (YY)	XX (YY)
	Primary target disease(s)			
	Experience in serving as an investigator (No. of trials/studies): ☐Yes (XX trials/studies) ☐No			
	Experience in serving as a subinvestigator (No. of trials/studies): ☐Yes (XX trials/studies) ☐No			
Remarks*				

*: If you have no experience in conducting clinical trials/post-marketing clinical studies during the previous approximately 2 years, but had experience in conducting them more than 2 years previously, briefly describe the trials/studies that you have been involved in.

Note) This form should be completed by the investigator and then be submitted to the head of the institution.

(Investigator) Form 2

Serial No.			
Category	■Clinical trial		
	☐Drug	☐Medical device	☐Regenerative medical product

Date: MM/DD/YYYY

List of Subinvestigator(s) and Clinical Trial Staff Members (☐New ☐Change)

To: Head of the institution
(Name of the institution) (Title of head officer)

From: Investigator
(Name)

I submit this form to request the inclusion of the individuals specified below as subinvestigator(s)/clinical trial staff members to whom I will delegate the trial-related duties and functions specified below:

Description

Chemical name or identification code of the test drug		Protocol No.	
Clinical trial title			

Name and department/title of the subinvestigator(s) and brief description of duties and functions delegated to the subinvestigator(s) (use separate sheets if there are more than 10 subinvestigators to be listed):

Name	Department or title	Brief description of delegated duties and functions
		☐General clinical trial duties and functions ☐ ( )
		☐General clinical trial duties and functions ☐ ( )
		☐General clinical trial duties and functions ☐ ( )
		☐General clinical trial duties and functions ☐ ( )
		☐General clinical trial duties and functions ☐ ( )
		☐General clinical trial duties and functions ☐ ( )
		☐General clinical trial duties and functions ☐ ( )
		☐General clinical trial duties and functions ☐ ( )
		☐General clinical trial duties and functions ☐ ( )
		☐General clinical trial duties and functions ☐ ( )

Name and department/title of clinical trial staff members and brief description of duties and functions delegated to each member (use separate sheets if there are more than 10 clinical trial staff members to be listed):

Name	Department or title	Brief description of duties to be shared
		☐General clinical trial assistant duties and functions ☐ ( )
		☐General clinical trial assistant duties and functions ☐ ( )
		☐General clinical trial assistant duties and functions ☐ ( )
		☐General clinical trial assistant duties and functions ☐ ( )
		☐General clinical trial assistant duties and functions ☐ ( )
		☐General clinical trial assistant duties and functions ☐ ( )
		☐General clinical trial assistant duties and functions ☐ ( )
		☐General clinical trial assistant duties and functions ☐ ( )
		☐General clinical trial assistant duties and functions ☐ ( )
		☐General clinical trial assistant duties and functions ☐ ( )

Date: MM/DD/YYYY

We hereby approve inclusion of the specified individuals as subinvestigator(s)/clinical trial staff members in the list for the above-mentioned clinical trial.

Head of the institution
(Name of the institution) (Title of head officer)

Note) This form should be completed by the investigator and then be submitted to the head of the institution. The head of the institution will fill out the fields for the date of approval and the name of the head of the institution at the bottom of the form and submit the form to the investigator.

(Investigator) Form 3

Serial No.			
Category	■Clinical trial		
	☐Drug	☐Medical device	☐Regenerative medical product

Date: MM/DD/YYYY

Clinical Trial Application Form

To: Head of the institution
(Name of the institution) (Title of head officer)

From: Sponsor-investigator
(Name)

I hereby apply to conduct the clinical trial specified below.

Description

Chemical name or identification code of the test drug		Protocol No.	
Clinical trial title	☐New clinical trial ☐Continuation of ongoing clinical trial		
	☐The clinical trial title specified above may be used in the outline of the institutional review board meeting minutes. Note: If you wish to rather use a different clinical trial title than the one specified above, specify it below.		
Investigational product provider			
Duration of the clinical trial	From MM/DD/YYYY to MM/DD/YYYY		

List of Attached Documents

Name of document	Date of preparation	Version No.
☐Protocol		
	Date: MM/DD/YYYY	
☐Investigator's Brochure		
	Date: MM/DD/YYYY	
☐Sample Case Report Form Note: Not required if the information to be provided in the case report form is fully clarified in the protocol.		
	Date: MM/DD/YYYY	
☐Written information for subject and informed consent form		
	Date: MM/DD/YYYY	
☐Written operating procedures for monitoring		
	Date: MM/DD/YYYY	
☐Audit plan and written operating procedures		
	Date: MM/DD/YYYY	
☐ List of prospective investigator (Curriculum Vitae)		
	Date: MM/DD/YYYY	
☐ List of prospective subinvestigator (Name List)		
	Date: MM/DD/YYYY	
☐Document concerning the control/accountability of the investigational product		
	Date: MM/DD/YYYY	
☐Document concerning notification		
	Date: MM/DD/YYYY	
☐Document concerning clinical trial expenses (Document concerning subject compensation (if any))		
	Date: MM/DD/YYYY	

☐Document concerning the compensation available to subjects in the event of trial-related injury		
	Date: MM/DD/YYYY	
☐Document concerning source document verification		
	Date: MM/DD/YYYY	
☐Document concerning premature clinical trial termination		
	Date: MM/DD/YYYY	
☐Document concerning subject recruitment procedures (e.g., advertisement)		
	Date: MM/DD/YYYY	
☐Document concerning subject safety		
	Date: MM/DD/YYYY	
☐Others		
	Date: MM/DD/YYYY	

Note) This form should be completed by the sponsor-investigator and then be submitted to the head of the institution.

(Investigator) Form 4

Serial No.			
Category	■Clinical trial		
	☐Drug	☐Medical device	☐Regenerative medical product

Date: MM/DD/YYYY

Clinical Trial Review Request Form

To: Chairperson of the Institutional Review Board
(Name of the institutional review board)

From: Head of the institution
(Name of the institution) (Title of head officer)

We hereby request to review the following review items:

Description

Name of the investigator			
Chemical name or identification code of the test drug		Protocol No.	
Clinical trial title			
Review items (Attached documents)	☐Appropriateness of conducting the clinical trial (Clinical Trial Application Form [(Investigator) Form 3 dated MM/DD/YYYY]) ☐Appropriateness of continuation of the clinical trial ☐Serious Adverse Event Report Form (☐For Clinical Trials of Drugs [(Investigator) Form 12 dated MM/DD/YYYY]) (☐For Clinical Trials of Medical Devices [(Investigator) Form 14 dated MM/DD/YYYY]) (☐For Clinical Trials of Regenerative Medical Products [(Investigator) Form 19 MM/DD/YYYY]) ☐Safety information (☐Safety Information Report [(Investigator) Form 16 dated MM/DD/YYYY]) (☐Safety Information Report [(Investigator) Form 16 dated MM/DD/YYYY]) ☐Clinical trial-related changes (☐Clinical Trial-related Change Application Form [(Investigator) Form 10 dated MM/DD/YYYY]) (☐Clinical Trial-related Change Application Form [(Investigator) Form 10 dated MM/DD/YYYY]) ☐Protocol deviations to eliminate immediate hazards (Report concerning Protocol Deviations to Eliminate Immediate Hazards [(Investigator) Form 8 dated MM/DD/YYYY]) ☐Review of the appropriateness of continuation of the clinical trial (Clinical Trial Progress Report [(Investigator) Form 11 dated MM/DD/YYYY]) ☐Others ( )		

Note) This form should be completed by the head of the institution and then be submitted to the institutional review board.

(Investigator) Form 5

Serial No.			
Category	■Clinical trial		
	☐Drug	☐Medical device	☐Regenerative medical product

Date: MM/DD/YYYY

Clinical Trial Review Results Notification

To: Head of the institution
(Name of the institution) (Title of head officer)

From: Institutional Review Board
(Name)
(Location)
(Name of the chairperson)

Regarding your request for review, we hereby notify you of the review result as follows:

Description

Chemical name or identification code of the test drug		Protocol No.	
Clinical trial title			
Review items (Review documents)	☐Appropriateness of conducting the clinical trial (Clinical Trial Application Form [(Investigator) Form 3 dated MM/DD/YYYY]) ☐Appropriateness of continuation of the clinical trial ☐Serious Adverse Event Report Form (☐For Clinical Trials of Drugs [(Investigator) Form 12 dated MM/DD/YYYY]) (☐For Clinical Trials of Medical Devices [(Investigator) Form 14 dated MM/DD/YYYY]) (☐For Clinical Trials of Regenerative Medical Products [(Investigator) Form 19 dated MM/DD/YYYY]) ☐Safety information (☐Safety Information Report [(Investigator) Form 16 dated MM/DD/YYYY]) (☐Safety Information Report [(Investigator) Form 16 dated MM/DD/YYYY]) ☐Clinical trial-related changes (☐Clinical Trial-related Change Application Form [(Investigator) Form 10 dated MM/DD/YYYY]) (☐Clinical Trial-related Change Application Form [(Investigator) Form 10 dated MM/DD/YYYY]) ☐Protocol deviations to eliminate immediate hazards (Report concerning Protocol Deviations to Eliminate Immediate Hazards [(Investigator) Form 8 dated MM/DD/YYYY]) ☐Review of the appropriateness of continuation of the clinical trial (Clinical Trial Progress Report [(Investigator) Form 11 dated MM/DD/YYYY]) ☐Others ( )		
Review category	☐Meeting review (date of review: MM/DD/YYYY) ☐Expedited review (date of the completion of review: MM/DD/YYYY)		
Review result	☐Approval ☐Approval with modifications ☐Disapproval ☐Termination of prior approval ☐Suspension		
Reason etc. for result other than “approval”			
Remarks			

Date: MM/DD/YYYY

To: Sponsor-investigator (Name)

Regarding the review items of the clinical trial you applied for, we hereby notify you of our decision as shown above.

From: Head of the institution
(Name of the institution) (Title of head officer)

Note) If the institutional review board simultaneously submits safety information to the head of the institution and the sponsor-investigator, this form should be completed by the institutional review board, and the field for the date of notification at the bottom of the form should not be used, but the field for the head of the institution must be filled out as “not applicable.” If safety information is not simultaneously submitted, or in case of other review items than safety information, this form should be completed by the institutional review board and then be submitted to the head of the institution. If the decision made by the institutional review board is consistent with the instructions

of the head of the institution, the head of the institution should fill out the fields for the date of the notification and the head of the institution at the bottom of the form, and submit the form to the sponsor-investigator. If these are not consistent, (Investigator) Reference Form 1 should be used.

(Investigator) Form 5

Serial No.	

Date: MM/DD/YYYY

List of Attendees/Absentees of the Institutional Review Board Members

Name	Occupation, qualification and department	Member category	Attendances/ absences	Remarks

Note) The category of each member should be described using the following category numbers:

(1) Members whose primary area of interest is in a nonscientific area

(2) Members who are independent of the institution (excluding members falling under category (1))

(3) Members who are independent of the founder of the institutional review board (excluding members falling under category (1))

(4) Members who are not classified as category (1), (2), or (3)

Attendances/absences should be noted using the following category symbols:

○: Members who attended the meeting, and who are not involved in the clinical trial

–: Members who attended the meeting, but did not participate in the review or voting due to involvement in the clinical trial

×: Members who were absent from the meeting

We confirm and guarantee that the institutional review board has been organized and engaged in its activities in accordance with the institutional review board's standard operating procedures, "Ministerial Ordinance on Good Clinical Practice for Drugs" (Ministry of Health and Welfare Ordinance No. 28 of 1997), "Ministerial Ordinance on Good Clinical Practice for Medical Devices" (Ministry of Health, Labour and Welfare Ordinance No. 36 of 2005), and "Ordinance on Good Clinical Practice of Regenerative Medical Products, etc." (Ministry of Health, Labour and Welfare Ordinance No. 89 of 2014).

(Investigator) Form 6

Serial No.			
Category	■Clinical trial		
	☐Drug	☐Medical device	☐Regenerative medical product

Date: MM/DD/YYYY

Protocol Modification Report

To: Head of the institution
(Name of the institution) (Title of head officer)

From: Sponsor-investigator
(Name)

Regarding the protocol notified as "approval with modifications" on MM/DD/YYYY, I hereby report that the protocol has been modified as follows:

Description

Chemical name or identification code of the test drug		Protocol No.	
Clinical trial title			
Condition/reason etc. for "approval with modifications"			
Action taken	Before modification	After modification	
Attached documents			

Regarding the clinical trial specified above, we have confirmed that the modification above meets the condition for approval.
Date: MM/DD/YYYY

Head of the institution
(Name of the institution) (Title of head officer)

Note) This form should be completed by the sponsor-investigator and then be submitted to the head of the institution. The head of the institution will fill out the fields for the date of confirmation and the head of the institution at the bottom of the form.

(Investigator) Form 8

Serial No.			
Category	■Clinical trial		
	☐Drug	☐Medical device	☐Regenerative medical product

Date: MM/DD/YYYY

Report concerning Protocol Deviations to Eliminate Immediate Hazards

To: Head of the institution
(Name of the institution) (Title of head officer)

From: Investigator
(Name)

Regarding the clinical trial specified below, I hereby report the occurrence of the following protocol deviation to eliminate immediate hazards to subjects:

Description

Chemical name or identification code of the test drug		Protocol No.	
Clinical trial title			

Subject identification code	

Description of the deviation (With the name of document[s], if attached)	Reason for the deviation

Note) This form should be completed by the investigator and then be submitted to the head of the institution.

(Investigator) Form 10

Serial No.			
Category	■Clinical trial		
	☐Drug	☐Medical device	☐Regenerative medical product

Date: MM/DD/YYYY

Clinical Trial-related Change Application Form

To: Head of the institution
(Name of the institution) (Title of head officer)

From: Sponsor-investigator
(Name)

Regarding the clinical trial specified below, I hereby apply for the following change:

Description

Chemical name or identification code of the test drug			Protocol No.	
Clinical trial title				
Document, etc. subject to the change	☐Protocol ☐Written information for subjects and informed consent form ☐Investigator's Brochure ☐Subinvestigator ☐Others ( )			
Description of the change	Change	Before change	After change	Reason for change
Attached documents				

Note) This form should be completed by the sponsor-investigator and then be submitted to the head of the institution.

(Investigator) Form 11

Serial No.			
Category	■Clinical trial		
	☐Drug	☐Medical device	☐Regenerative medical product

Date: MM/DD/YYYY

Clinical Trial Progress Report

To: Head of the institution
(Name of the institution) (Title of head officer)

From: Investigator
(Name)

I hereby report the progress of the clinical trial specified below as follows:

Description

Chemical name or identification code of the test drug		Protocol No.	
Clinical trial title			
Actual status	No. of subjects from whom informed consent has been obtained: XX No. of subjects enrolled in the trial: XX (including YY subjects who completed the protocol and ZZ subjects who withdrew from the trial) (As of MM/DD/YYYY)		
Duration of the clinical trial	From MM/DD/YYYY to MM/DD/YYYY		
Progress of the clinical trial	Safety Compliance with GCP Others (e.g., reasons for subject withdrawal from the trial)		

Note) This form should be completed by the investigator and then be submitted to the head of the institution.

(Investigator) Form 12

Serial No.	
Category	■Clinical trial ■Drug

Date: MM/DD/YYYY

Serious Adverse Event Report (XXth Report)

To: Head of the institution
(Name of the institution) (Title of head officer)
To: Investigators of other institutions
To: Investigational product provider
(Name)

From: Investigator
(Name)

I hereby report that the following adverse event determined to be serious was observed in the clinical trial specified below:

Description

Chemical name or identification code of the test drug		Protocol No.	
Clinical trial title			

Subject identification code*	

*: If the event was observed in a fetus/offspring, the identification code of the subject (parent) should be provided.

Information concerning the individual experiencing the serious adverse event

Category of the individual experiencing the event ☐Subject ☐Fetus ☐Offspring	Body weight: kg Height: cm	Date of birth (MM/DD/YYYY): / / Age: XX (XX weeks of age [for fetus])	Predisposition of the subject (e.g., hypersensitivity) ☐No ☐Yes ( )
	Sex: ☐Male ☐Female	Date of menstruation before event onset (MM/DD/YYYY): / / (Gestation at event onset in the fetus: XX weeks)	

Information concerning the serious adverse event

Detailed information ☐Yes (☐Standard Forms ☐Other forms) ☐No

Event term (diagnosis) Expectedness of event with respect to the investigational product	Date of event onset (MM/DD/YYYY)	Reason why event was determined to be serious Date when event was determined to be serious (MM/DD/YYYY)	Outcome of the event Date when the outcome was determined (MM/DD/YYYY)
☐Expected ☐Unexpected	/ /	(/ /) ☐Results in death ☐Is life-threatening ☐Requires inpatient hospitalization or prolongation of existing hospitalization ☐Results in persistent or significant disability/incapacity ☐Is a congenital anomaly/birth defect ☐Other important medical events	(/ /) ☐Recovered/resolved ☐Recovering/resolving ☐Not Recovered/not resolved/ongoing ☐Recovered/resolved with sequelae ☐Fatal ☐Unknown

Information concerning the investigational product

Investigational product	Treatment duration (MM/DD/YYYY)	Causal relationship with the event	Action taken after event onset Dosage regimen after dose modification
☐Test product (blinded) ☐Test product ☐Others	/ / to ☐ / / ☐Ongoing	☐Related ☐Not related	☐Drug withdrawn ☐Unchanged ☐Unknown ☐Not applicable ☐Dose reduced ☐Dose increased

Name of the drug: Brand/nonproprietary name	Dosage regimen during the treatment period		Dosage regimen after dose modification

Remarks: For clinical trials of combination products, it should be clarified that there are other report forms related to this report. Other comments, if any, should also be provided.

Attached documents	

Note) This form should be completed by the investigator and then be submitted to the head of the institution, the investigators of other institutions and the investigational product provider.

(Investigator) Form 14

Serial No.	
Category	■ Clinical trial ■ Medical device

Date: MM/DD/YYYY

Serious Adverse Event and Medical Device Malfunction Report (XXth Report)

To: Head of the institution
(Name of the institution) (Title of head officer)
To: Investigators of other institutions
To: Investigational device provider
(Name)

From: Investigator
(Name)

I hereby report that the following ☐adverse event determined to be serious ☐malfunction that may cause a serious adverse event was observed in the clinical trial specified below:

Description

Name of material or identification code of the test device		Protocol No.	
Clinical trial title			

Subject identification code*	

*: If the event was observed in a fetus/offspring, the identification code of the subject (parent) should be provided.

Information concerning the individual experiencing the serious adverse event, etc.

Category of the individual experiencing the event ☐Subject ☐Fetus ☐Offspring ☐Others ( )	Body weight: kg Height: cm	Date of birth (MM/DD/YYYY): / / Age: XX (XX weeks of age [for fetus])	Predisposition of the subject (e.g., hypersensitivity) ☐No ☐Yes ( )
	Sex: ☐Male ☐Female	Date of menstruation before event onset (MM/DD/YYYY): / / (Gestation at event onset in the fetus: XX weeks)	

Information concerning the serious adverse event

Detailed information ☐Yes (☐Standard Forms) ☐No ☐Not applicable

Event term (diagnosis) Expectedness for the investigational device	Date of event onset (MM/DD/YYYY)	Reason why event was determined to be serious Date when event was determined to be serious (MM/DD/YYYY)	Outcome of the event Date when the outcome was determined (MM/DD/YYYY)
☐Expected ☐Unexpected	/ /	(/ /) ☐Results in death ☐Is life-threatening ☐Requires inpatient hospitalization or prolongation of existing hospitalization ☐Results in persistent or significant disability/incapacity ☐Is a congenital anomaly/birth defect ☐Other important medical events	(/ /) ☐Recovered/resolved ☐Recovering/resolving ☐Not recovered/not resolved/ongoing ☐Recovered/resolved with sequelae ☐Fatal ☐Unknown ☐Not applicable

Information concerning the investigational device (including procedures)

Investigational device	Date/duration of use (MM/DD/YYYY)	Causal relationship with the event	Action taken against the event caused by the investigational device
☐Procedure	/ / to ☐ / / ☐Ongoing	☐Related ☐Probably related ☐Possibly related ☐Not related ☐Unknown	

		☐Not applicable	
☐Test device (blinded) ☐Test device ☐Others Lot No.	/ / to ☐ / / ☐Currently in use	☐Related ☐Probably related ☐Possibly related ☐Not related ☐Unknown ☐Not applicable	☐Yes ☐No ☐Not applicable

Note) This form should be completed by the investigator and then be submitted to the head of the institution, the investigators of other institutions and the investigational device provider.

Serial No.	

Information concerning the investigational device malfunction ☐Not applicable

Name of the device malfunction			☐Expected ☐Unexpected
Date of onset of the investigational device malfunction	(HH:MM on MM/DD/YYYY): / / :		
Possible cause of the investigational device malfunction	Transportation/ storage	☐Yes Specify: ☐No	
	Procedure	☐Yes Specify: ☐No	
	Concomitant medications Concomitant therapies	☐Yes Specify: ☐No	
	Others		
Description of the investigational device malfunction	Specify the clinical course of the malfunction of the investigational device (including procedures) and the condition of the investigational device (e.g., structural/material/functional defect). If the device malfunction occurred after use of the device, clarify whether the device has been left in the body or has been removed.		

Reason for considering that the investigational device malfunction may cause a serious adverse event

Remarks: For clinical trials of combination products, it should be clarified that there are other report forms related to this report. Other comments, if any, should also be provided.

Attached documents	

(Investigator) Form 16

Serial No.			
Category	■Clinical trial		
	☐Drug	☐Medical device	☐Regenerative medical product

Date: MM/DD/YYYY

Safety Information Report

To: Head of the institution
(Name of the institution) (Title of head officer)
To: Investigators of other institutions
To: Chairperson of the Institutional Review Board
(Name of the institutional review board)

From: Sponsor-investigator
(Name)

I hereby report that the following information was obtained in the clinical trial specified below:

Description

Chemical name or identification code of the test drug		Protocol No.	
Clinical trial title			
Outline of the safety information	☐Individual case report ☐1. Resulting in death/ life-threatening (☐Domestic ☐Foreign) ☐2. Other serious (☐Domestic ☐Foreign)		
	☐Annual report (Reporting period: MM/DD/YYYY to MM/DD/YYYY) ☐Research report ☐Safety measure report ☐Notices of Revision of Precautions ☐Others ( )		
Sponsor-investigator's opinion	Continuation of the clinical trial ☐Yes ☐No Revision of the protocol ☐Not required ☐Required Revision of the written information for subjects and informed consent form ☐Not required ☐Required Others ( )		
Attached documents			
Remarks			

Note) This form should be completed by the sponsor-investigator and then be submitted to the head of the institution and the investigators of other institutions. If it is agreed in advance to submit it to the institutional review board, the form should also be submitted to the institutional review board. If the form is not submitted to the institutional review board, the name of the institutional review board should be filled out as "not applicable." If the form is submitted by the clinical trial coordination committee to investigators of other institutions, the field for investigators of other institutions should be crossed out with a double line, or be filled out as "not applicable."

(Investigator) Form 17

Serial No.			
Category	■Clinical trial		
	☐Drug	☐Medical device	☐Regenerative medical product

Date: MM/DD/YYYY

Clinical Trial Completion (Premature Termination/Suspension) Report

To: Head of the institution
(Name of the institution) (Title of head officer)

From: Investigator
(Name)

I hereby report that the clinical trial specified below was ☐completed ☐prematurely terminated ☐suspended as follows:

Description

Chemical name or identification code of the test drug		Protocol No.	
Clinical trial title			
Actual status	No. of subjects from whom informed consent has been obtained: XX No. of subjects enrolled in the trial: XX		
Duration of the clinical trial	From MM/DD/YYYY to MM/DD/YYYY		
Overview of clinical trial results, etc. (If the trial was prematurely terminated or suspended, specify the reason.)	Efficacy Safety Compliance with GCP Others		

Date: MM/DD/YYYY

To: Chairperson of the Institutional Review Board (Name of the institutional review board)

Regarding the clinical trial specified above, we hereby notify you that it was reported as above by the investigator.

From: Head of the institution
(Name of the institution) (Title of head officer)

Note) This form should be completed by the investigator and then be submitted to the head of the institution. The head of the institution will fill out the fields for the date of notification and the head of the institution at the bottom of the form, and submit the form to the institutional review board.

(Investigator) Form 18

Serial No.			
Category	■Clinical trial		
	☐Drug	☐Medical device	☐Regenerative medical product

Date: MM/DD/YYYY

Development Discontinuation Report

To: Head of the institution
(Name of the institution) (Title of head officer)

From: Sponsor-investigator
(Name)

Regarding the clinical trial specified below, I hereby report as follows:

Description

Chemical name or identification code of the test drug		Protocol No.	
Clinical trial title			
Duration of the clinical trial	From MM/DD/YYYY to MM/DD/YYYY		
Information reported	☐For the reason specified in the attachment, we, on MM/DD/YYYY will: ☐Discontinue the development of the test drug. ☐Prematurely terminate the clinical trial. ☐Suspend the clinical trial ☐Obtainment of marketing approval (Date: MM/DD/YYYY) ☐Notification of results of reexamination (Date: MM/DD/YYYY)		
Document retention, etc.	Regarding clinical trial documents currently retained, follow the following procedure: ☐Discard the documents. ☐Retain the documents until MM/DD/YYYY. ☐Others ( )		

Date: MM/DD/YYYY

To: Chairperson of the Institutional Review Board (Name of the institutional review board)

Regarding the clinical trial specified above, we hereby notify that we have received the above report from the sponsor-investigator:

From: Head of the institution
(Name of the institution) (Title of head officer)

Note) This form should be completed by the sponsor-investigator and then be submitted to the head of the institution. The head of the institution will fill out the fields for the date of notification and the head of the institution at the bottom of the form, and submit the form to the institutional review board. If “Obtainment of marketing approval” or “Notification of results of reexamination” is selected in the “Information reported” section and submission of the form to the institutional review board is considered unnecessary, the bottom of the form will not be used.

(Investigator) Form 19

Serial No.	
Category	■Clinical trial ■Regenerative medical product

Date: MM/DD/YYYY

Serious Adverse Event and Malfunction Report (XXth Report)

To: Head of the institution
(Name of the institution) (Title of head officer)
To: Investigators of other institutions
To: Investigational product provider
(Name)

From: Investigator
(Name)

I hereby report that the following ☐adverse event determined to be serious ☐malfunction that may cause a serious adverse event was observed in the clinical trial specified below:

Description

Name of material or identification code of the test product		Protocol No.	
Clinical trial title			

Subject identification code*	

*: If the event was observed in a fetus/offspring, the identification code of the subject (parent) should be provided.

Information concerning the individual experiencing the serious adverse event, etc.

Category of the individual experiencing the event ☐Subject ☐Fetus ☐Offspring ☐Others ( )	Body weight: kg Height: cm	Date of birth (MM/DD/YYYY): / / Age: XX (XX weeks of age [for fetus])	Predisposition of the subject (e.g., hypersensitivity) ☐No ☐Yes ( )
	Sex: ☐Male ☐Female	Date of menstruation before event onset (MM/DD/YYYY): / / (Gestation at event onset in the fetus: XX weeks)	

Information concerning the serious adverse event

Detailed information ☐Yes (Standard Forms) ☐No ☐Not applicable

Event term (diagnosis) Expectedness of event with respect to the investigational product	Date of event onset (MM/DD/YYYY)	Reason why event was determined to be serious Date when event was determined to be serious (MM/DD/YYYY)	Outcome of the event Date when the outcome was determined (MM/DD/YYYY)
☐Expected ☐Unexpected	/ /	(/ /) ☐Results in death ☐Is life-threatening ☐Requires inpatient hospitalization or prolongation of existing hospitalization ☐Results in persistent or significant disability/incapacity ☐Is a congenital anomaly/birth defect ☐Other important medical events	(/ /) ☐Recovered/resolved ☐Recovering/resolving ☐Not recovered/not resolved/ongoing ☐Recovered/resolved with sequelae ☐Fatal ☐Unknown ☐Not applicable

Information concerning the investigational product (including procedures)

Investigational product, etc.	Date/duration of use (MM/DD/YYYY)	Causal relationship with the event	Action taken against the event caused by the investigational product
☐Procedure**	/ / to ☐ / / ☐Ongoing	☐Related ☐Probably related ☐Possibly related ☐Not related ☐Unknown	

		☐Not applicable	
☐Test product (blinded) ☐Test product ☐Others Lot No.	/ / to ☐ / / ☐Currently in use	☐Related ☐Probably related ☐Possibly related ☐Not related ☐Unknown ☐Not applicable	☐Yes ☐No ☐Not applicable

**: Procedures include a series of pretreatments/preparation for cell sampling.

Note) This form should be completed by the investigator and then be submitted to the head of the institution, the investigators of other institutions and the investigational product provider.

(Investigator) Form 19

Serial No.	

Information concerning the investigational product malfunction ☐Not applicable

Name of the product malfunction			☐Expected ☐Unexpected
Date of onset of the investigational product malfunction	(HH:MM on MM/DD/YYYY): / / :		
Possible cause of the investigational product malfunction	Transportation/ storage	☐Yes Specify: ☐No	
	Procedure	☐Yes Specify: ☐No	
	Underlying diseases	☐Yes Specify: ☐No	
	Concomitant medications Concomitant therapies	☐Yes Specify: ☐No	
	Others		
Description of the investigational product malfunction	Specify the clinical course of the malfunction of the investigational product (including procedures) and the condition of the investigational product (e.g., structural/material/functional defect). If the product malfunction occurred after use of the product, clarify whether the product has been left in the body or has been removed.		

Reason for considering that the investigational product malfunction may cause a serious adverse event

Remarks: For clinical trials of combination products, it should be clarified that there are other report forms related to this report if more than one malfunction has to be reported. Other comments, if any, should also be provided.

Attached documents	

(Investigator) Form for detailed description

Serial No.	

Underlying diseases, complicating conditions, medical history, and previous treatments believed to be related to the serious adverse event (e.g., surgical procedures, radiotherapy, blood transfusion, etc.)

	Name of disease	Date of onset (MM/DD/YYYY)	Status at the time of reporting (MM/DD/YYYY)
Underlying diseases, complicating conditions, and medical history		/ /	☐Persisting ☐Cured (/ /) ☐Unknown
		/ /	☐Persisting ☐Cured (/ /) ☐Unknown
		/ /	☐Persisting ☐Cured (/ /) ☐Unknown
		/ /	☐Persisting ☐Cured (/ /) ☐Unknown
		/ /	☐Persisting ☐Cured (/ /) ☐Unknown
		/ /	☐Persisting ☐Cured (/ /) ☐Unknown
		/ /	☐Persisting ☐Cured (/ /) ☐Unknown
		/ /	☐Persisting ☐Cured (/ /) ☐Unknown

Surgical procedures, radiotherapy, blood transfusion, etc.	Date of initiation (MM/DD/YYYY)	Status at the time of reporting (MM/DD/YYYY)
	/ /	☐Persisting ☐Cured (/ /) ☐Unknown
	/ /	☐Persisting ☐Cured (/ /) ☐Unknown
	/ /	☐Persisting ☐Cured (/ /) ☐Unknown

Medications used at the onset of the serious adverse event

(Excluding those used for treatment of the serious adverse event)

Name of the drug: Brand/nonproprietary name	Dosage regimen	Treatment duration (MM/DD/YYYY)	Reason for use	Causal relationship	Action taken after event onset
	Dosage form/route of administration Dosage regimen	/ / to ☐ / / ☐Ongoing		☐Related ☐Not related	☐Drug withdrawn ☐Unchanged ☐Unknown ☐Dose reduced ☐Dose increased
	Dosage form/route of administration Dosage regimen	/ / to ☐ / / ☐Ongoing		☐Related ☐Not related	☐Drug withdrawn ☐Unchanged ☐Unknown ☐Dose reduced ☐Dose increased
	Dosage form/route of administration Dosage regimen	/ / to ☐ / / ☐Ongoing		☐Related ☐Not related	☐Drug withdrawn ☐Unchanged ☐Unknown ☐Dose reduced ☐Dose increased
	Dosage form/route of administration Dosage regimen	/ / to ☐ / / ☐Ongoing		☐Related ☐Not related	☐Drug withdrawn ☐Unchanged ☐Unknown ☐Dose reduced ☐Dose increased

Remarks	

(Investigator) Form for detailed description

Serial No.	

Information concerning readministration of medications used at time of occurrence of serious adverse event

Name of drug readministrated (Brand/nonproprietary name)	Dosage regimen	Readministration period (MM/DD/YYYY)	Onset of adverse event after readministration
		/ / to ☐ / / ☐Ongoing	☐No ☐Yes [ ]
		/ / to ☐ / / ☐Ongoing	☐No ☐Yes [ ]
		/ / to ☐ / / ☐Ongoing	☐No ☐Yes [ ]

Previous medications believed to be important in the assessment of the serious adverse event

Name of the drug (brand/nonproprietary name)	Treatment duration (MM/DD/YYYY)	Reason for use	Onset of adverse drug reaction
	/ / to / /		☐No ☐Yes [ ]
	/ / to / /		☐No ☐Yes [ ]
	/ / to / /		☐No ☐Yes [ ]

Laboratory test results believed to be related to the onset of the serious adverse event (Test slips (copies) may be provided as attachments.)

Test	Unit	Reference range		Results			
		Lower limit	Upper limit	MM/DD/YYYY / /	MM/DD/YYYY / /	MM/DD/YYYY / /	MM/DD/YYYY / /

Other laboratory test results (ECG records, X-ray images, etc. may be provided as attachments.)

(Investigator) Form for detailed description

Serial No.	

Clinical course: Provide an overview of the subject, including detailed time course before the onset of the serious adverse event, actions taken for the event, the outcome of the event, and other relevant information.

MM/DD/YYYY	Description
/ /	
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Comments: Specify the rationale for assessment of the causal relationship with the investigational product, diagnosis of the serious adverse event, seriousness of the event, interactions between drugs used, etc.

Fatal case:

Autopsy: ☐No ☐Yes	If "yes," specify the cause of death confirmed by autopsy:	If "no," specify the presumed or confirmed cause of death:

(Investigator) Form for detailed description

Serial No.	

Information concerning the subject (parent) in case a serious adverse event affecting the offspring/fetus only

Subject identification code:	Body weight: kg Height: cm	Date of birth (MM/DD/YYYY): / / Age: XX	Predisposition of the subject (e.g., hypersensitivity) ☐No ☐Yes ( )
Sex: ☐Male ☐Female	Date of menstruation before event onset (MM/DD/YYYY): / / (Pregnancy at the start of treatment with the suspect drug: ☐No ☐Yes: XX weeks ☐Unknown)		

Underlying diseases, complicating conditions, medical history, and previous treatments believed to be related to the serious adverse event (e.g., surgical procedures, radiotherapy, blood transfusion, etc.)

	Name of disease	Date of onset (MM/DD/YYYY)	Status at the time of reporting (MM/DD/YYYY)
Underlying diseases, complicating conditions, and medical history		/ /	☐Persisting ☐Cured (/ /) ☐Unknown
		/ /	☐Persisting ☐Cured (/ /) ☐Unknown
		/ /	☐Persisting ☐Cured (/ /) ☐Unknown
		/ /	☐Persisting ☐Cured (/ /) ☐Unknown
		/ /	☐Persisting ☐Cured (/ /) ☐Unknown
		/ /	☐Persisting ☐Cured (/ /) ☐Unknown

Surgical procedures, radiotherapy, blood transfusion, etc.	Date of initiation (MM/DD/YYYY)	Status at the time of reporting (MM/DD/YYYY)
	/ /	☐Persisting ☐Cured (/ /) ☐Unknown
	/ /	☐Persisting ☐Cured (/ /) ☐Unknown
	/ /	☐Persisting ☐Cured (/ /) ☐Unknown
	/ /	☐Persisting ☐Cured (/ /) ☐Unknown

Previous medications believed to be important in the assessment of the serious adverse event

Name of the drug (Brand/nonproprietary name)	Treatment duration (MM/DD/YYYY)	Reason for use	Onset of adverse drug reaction
	/ / to / /		☐No ☐Yes [ ]
	/ / to / /		☐No ☐Yes [ ]
	/ / to / /		☐No ☐Yes [ ]

(Investigator) Reference Form 1

Serial No.			
Category	■Clinical trial		
	☐Drug	☐Medical device	☐Regenerative medical product

Date: MM/DD/YYYY

Notification of Clinical Trial-related Instructions/Decisions

To: Sponsor-investigator
(Name)

From: Head of the institution
(Name of the institution) (Title of head officer)

Regarding the review items of the clinical trial you applied for, we hereby notify of our decision as follows:

Description

Chemical name or identification code of the test drug			Protocol No.	
Clinical trial title				
Investigational product provider				
Description of instruction/decision	Review items (Review documents)	☐Clinical Trial Review Results Notification attached ([Investigator] Form 5 dated MM/DD/YYYY) As indicated in the "Review items (review documents)" field. ☐Others ( )		
	Handling	☐Approval with modifications ☐Disapproval ☐Termination of prior approval ☐Suspension		
	Condition of/reason for the "handling"			
Remarks				

Note) This form should be completed by the head of the institution and then be submitted to the sponsor-investigator.

(Investigator) Reference Form 2

Serial No.			
Category	■Clinical trial		
	☐Drug	☐Medical device	☐Regenerative medical product

Date: MM/DD/YYYY

Source Document Verification Application Form

To: Clinical Trial Secretariat, (Name of the institution)

From: Source Document Verification Applicant
(Name of the institution/department)
(Name of the applicant)

Regarding the clinical trial specified below, I hereby apply for source document verification (☐monitoring, ☐audit) as follows:

Description

Chemical name or identification code of the test drug		Protocol No.	
Clinical trial title			
Desired date of source document verification	From HH:MM to HH:MM on MM/DD/YYYY		
Contact information of the person performing source document verification	TEL: FAX: E-mail:		
Witness (If applicable)	☐Investigator ☐Subinvestigator ☐Trial staff member ☐Others ( )		
Subject identification code	Documents subject to source document verification		
	☐Medical record (outpatient/inpatient) ☐Case Report Form ☐Subject diary ☐Investigational product accountability log ☐Others ( )		
	☐Medical record (outpatient/inpatient) ☐Case Report Form ☐Subject diary ☐Investigational product accountability log ☐Others ( )		
	☐Medical record (outpatient/inpatient) ☐Case Report Form ☐Subject diary ☐Investigational product accountability log ☐Others ( )		
	☐Medical record (outpatient/inpatient) ☐Case Report Form ☐Subject diary ☐Investigational product accountability log ☐Others ( )		
	☐Medical record (outpatient/inpatient) ☐Case Report Form ☐Subject diary ☐Investigational product accountability log ☐Others ( )		
Other clinical trial documents	☐Institutional Review Board meeting minutes ☐Others ( )		
Documents to be borrowed	☐Prescription drug formulary ☐Others ( )		
Remarks			

Date: MM/DD/YYYY

Confirmation Field

Message from the Clinical Trial Secretariat	☐We accept your request for source document verification as indicated above. The date and time of source document verification are: HH:MM to HH:MM on MM/DD/YYYY. ☐Others ( )
Contact information of the person in charge of the Clinical Trial Secretariat (contact point)	Name: Department: TEL: FAX: E-mail:

Note) This form should be completed by the source document verification applicant (the person in charge) and then be submitted to the Clinical Trial Secretariat via FAX or E-mail. The Clinical Trial Secretariat will review the form, fill out the confirmation field, and send it via FAX or E-mail.

Precautions for completing Standard Forms

(For Investigator-initiated Clinical Trials)

General instructions

[1] The western calendar should be used for year of the date.

[2] Serial No.: The serial number should be provided by the institution as necessary.

[3] Category: Either “drug”, “medical device”, or “regenerative medical product” should be selected depending on the type of clinical trial.

[4] For (Investigator) Forms 1 to 11, (Investigator) Forms 16 to 18, and (Investigator) Reference Forms 1 and 2, terms should be replaced based on the selected category according to the table below. This term replacement also applies to these precautions for completing the Standard Forms.

In the form	Clinical trial	
	Medical device	Regenerative medical product
Investigational product	Investigational device	Investigational product
Test drug	Test device	Test product

[5] The sponsor-investigator (principal investigator) and the institution should discuss whether the name and seal or signature are required or not.

[6] Handling of confirmation by the department director: This item is not required by GCP, and there is not a field for confirmation by the department director in the Standard Forms. If such a confirmation is required by the institutional procedures, the Clinical Trial Secretariat may provide the department director with a duplicate copy of the document prepared by the sponsor-investigator or the investigator as necessary.

[7] If there is not enough space for the description in each form, an attachment (regardless of format) may be used. In this case, the field in the form should be filled out as “See the attachment.” “Regardless of format” means that it is not necessary to use a specific format as long as the required information is provided appropriately and clearly.

[8] Chemical name or identification code of the test drug: For clinical trials of drugs, the chemical name or identification code of the test drug should be provided. For clinical trials of medical devices, the name of the materials or identification code of the test device should be provided. For clinical trials of regenerative medical products, the component cells, transgenes, or identification code of the test product should be provided.

[9] Duration of the clinical trial: Duration of the clinical trial specified in the protocol should be provided.

[10] Investigational product provider: The name of the company should be provided.

[11] In the forms for investigator-initiated clinical trials, a “person who intends to be sponsor-investigator” and a “sponsor-investigator” are collectively referred to as the “sponsor-investigator.”

[12] Name of document, attached documents: The name of a file that identifies the document may be provided. For file names, refer to “Partial Revision of Basic Principals Regarding Utilization of Electromagnetic Records in Clinical Trial-related Documents” (Administrative Notice issued on July 1, 2014 by the Evaluation and Licensing Division, Pharmaceutical and Food Safety Bureau, Ministry of Health, Labour and Welfare).

(Investigator) Form 1 (Curriculum Vitae)

[1] Mark “Investigator” or “Subinvestigator.” For subinvestigators, curriculum vitae should be prepared if

requested.

[2] Name of institution: Provide the name of the institution that the investigator/subinvestigator currently belongs to.

[3] Department/title: Provide the name of the department/title in the institution.

[4] Educational record (university): Provide the name of the university and department that the investigator/subinvestigator graduated from and the year of graduation. Information regarding graduate school is not required.

[5] License (license #): Mark "Medical doctor" and/or "Dentist," and provide the license number and the year of qualification.

[6] Qualifications for board-certified physician, etc.: Mainly information related to clinical trials etc. should be provided. It is not necessary to provide all qualifications obtained.

[7] Employment record: As an employment record of the investigator/subinvestigator for the previous approximately 5 years, the name of the institution, department, duration, and other relevant information should be provided. If there is not enough space for the description in the form, an attachment may be used. In this case, the field in the form should be filled out as "See attachment."

[8] Major research content, books/literature articles, etc.: Information related to clinical trials etc. for the previous approximately 2 years should be provided. Not more than the 10 latest publications should be provided. If there is not enough space for the description in the form, an attachment may be used. In this case, the field in the form should be filled out as "See the attachment."

[9] Experience in conducting clinical trials/post-marketing clinical studies: If there was no experience in the previous approximately 2 years, enter "0" in this field. If the investigator/subinvestigator had earlier experience in conducting clinical trials/post-marketing clinical studies, briefly describe in the field for remarks the trials/studies that he/she has been involved in.

[10] Experience in conducting clinical trials/post-marketing clinical studies: No. of trials/studies: Provide the total number of clinical trials and post-marketing clinical studies that the investigator/subinvestigator has been involved in as an investigator/subinvestigator in the previous approximately 2 years as well as the number of ongoing trials/studies (the number of protocols) that the investigator/subinvestigator is currently involved in by drug, medical device, and regenerative medical product. Concerning the number of trials/studies, provide the number of trials/studies in which the investigator/subinvestigator has served as an investigator/subinvestigator, regardless of whether he/she has successfully enrolled subjects.

[11] Remarks: Provide any information worth noting.

[12] It is not necessary to fill out all the fields if it is shown in the form that the investigator/subinvestigator is capable of conducting the clinical trial or performing assigned duties and functions in an appropriate manner.

[13] If any changes occur in the information provided in the form during the clinical trial, it is not necessary to update or re-submit the form, as long as the changes will not affect the trial organization (e.g., department/title, name, and experience in conducting clinical trials/post-marketing clinical studies).

(Investigator) Form 2 (List of Subinvestigator(s) and Clinical Trial Staff Members)

[1] Mark either "New" or "Change." If only the department or title changes, it is not necessary to complete this form.

[2] Brief description of duties to be shared: Mark either "General clinical trial duties and functions" or

"General clinical trial assistant duties and functions." If the subinvestigator is clearly responsible for a certain duty and function, or the clinical trial staff member is not a subinvestigator, mark the checkbox on the right before the parentheses and specify the duty and function in the parentheses. This also applies when general duties and functions are specified in detail. If there is not enough space for the description, an attachment may be used. In this case, the parentheses should be filled out as "See the attachment."

[3] Department or title: Department or title should be provided if required by the institution.

[4] According to GCP, (Investigator) Form 2 is not subject to review by the institutional review board. It should be noted, however, that a document providing the name of the individual who will serve as a subinvestigator is subject to review.

(Investigator) Form 3 (Clinical Trial Application Form)

[1] Clinical trial title: Enter the clinical trial title in the upper part of this section. Enter the agenda (title) used for the outline of the institutional review board meeting minutes prepared by the individual who founded the institutional review board in the lower part of this section. If the sponsor-investigator rather wishes to use a different title from the clinical trial title, follow Clause 2-6-2, Article 28 of the GCP Guidance for Drugs or Clause 2-6-2, Article 47 of the GCP Guidance for Medical Devices. This also applies to regenerative medical products.

[2] List of Attached Documents: The name of each attachment should be marked. Provide specific names for these documents as well as the date of preparation and the version number necessary to identify each document (it is not necessary to provide both the date of preparation and the version number if the document can be identified). For example, the date of preparation and the version number are usually provided for a protocol, because it is revised as necessary. "None" should be entered in the field for version number. For other documents that can be identified by their names (e.g., documents concerning the anticipated clinical trial expenses, etc.)

[3] List of Attached Documents: Investigator's Brochure: The name of the Investigator's Brochure for the investigational product or other equivalent documents should be provided for clinical trials of drugs. The name of the Investigator's Brochure for the investigational device or other equivalent documents should be provided for clinical trials of medical devices. The name of the Investigator's Brochure for the investigational product or other equivalent documents should be provided for clinical trials of regenerative medical products.

[4] List of Attached Documents: A list of prospective subinvestigators (Name List) may be used in place of the "List of Subinvestigators and Clinical Trial Staff Members" ([Investigator] Form 2).

[5] List of Attached Documents: Others: Provide the name of attached documents, including documents provided to subjects (e.g., subject diary), the document regarding the scope of duties and functions of the contract research organization, the document regarding other drugs with similar pharmacological effects and/or indications (for drugs), and the document regarding a similar medical device (for medical devices).

(Investigator) Form 4 (Clinical Trial Review Request Form)

[1] Review items (Attached documents): Mark each applicable item. If there are additional items, mark "Others" and provide a brief description.

[2] If the sponsor-investigator simultaneously submits the "Safety Information Report" ([Investigator] Form 16) to the institutional review board in addition to the head of the institution, it may be regarded that the

head of the institution has provided the institutional review board with the necessary written information related to the "Safety Information Report" ([Investigator] Form 16), and it is therefore not necessary to prepare (Investigator) Form 4.

(Investigator) Form 5 (Clinical Trial Review Results Notification)

[1] Review items (Review documents): Mark each applicable item, and provide the date of the reviewed documents.

[2] Category of review: date of review: Provide the date of the institutional review board meeting. Date of the completion of review: Provide the date of the completion of expedited review.

[3] Review result: Mark each applicable item. If more than one item is reviewed and the review results differ across the review items, a notification may be issued for each review result, or different review results may separately be provided in the same notification as appropriate.

[4] Member categories: The category of each member should be described using the following category numbers:

(1) Members whose primary area of interest is in a nonscientific area

(2) Members who are independent of the institution (excluding members falling under category (1))

(3) Members who are independent of the founder of the institutional review board (excluding members falling under category (1))

(4) Members who are not classified as category (1), (2), or (3)

[5] Attendances/absences: Members who attended the meeting and are not involved in the clinical trial should be marked as "○", members who attended the meeting but did not participate in the review or voting due to involvement in the clinical trial should be marked as "–", and members who were absent from the meeting should be marked as "×".

[6] In cases involving expedited review, provide the names of the members who performed the review in the List of Attendees/Absentees of the Institutional Review Board Members. If the number of members is small, provide the required information, including the names of the members, in the "Remarks" field on the first page.

[7] The first and second pages are a set of documents, and the same date of preparation should therefore be provided.

[8] Remarks (first page): The "Remarks" field should be filled out only if there are additional comments to be made (e.g., approved but with comments).

[9] Remarks (second page): The "Remarks" field should be filled out only if there are additional comments to be made (e.g., the name of the chairperson is required).

[10] If the sponsor-investigator simultaneously submits the "Safety Information Report" ([Investigator] Form 16) to the institutional review board in addition to the head of the institution, the institutional review board may use (Investigator) Form 5 to provide an opinion only on the appropriateness of continuing the clinical trial in relation to the "Safety Information Report" ([Investigator] Form 16) to the sponsor-investigator, in addition to the head of the institution. In this case it may be regarded that the head of the institution has provided the necessary information to the sponsor-investigator.

[11] If an agreement is made regarding the procedure specified in [10] above, and approval is obtained from the sponsor-investigator, the institutional review board, and the head of the institution, the name of the institution and the title of the head officer of the institution may be described as "the head of each

institution."

[12] If the decision made by the institutional review board is consistent with the instructions given by the head of the institution, the field below the table in (Investigator) Form 5 may be used. If these are not consistent, the "Notification of Clinical Trial-related Instructions/Decisions" ([Investigator] Reference Form 1) should be used.

(Investigator) Form 6 (Protocol Modification Report)

[1] Condition/reason etc. for "approval with modifications": Enter the information provided in the field for the reason for not being "approval" in the "Clinical Trial Review Results Notification" ([Investigator] Form 5) (if the decision made by the institutional review board is consistent with the instructions given by the head of the institution) or in the applicable field in the "Notification of Clinical Trial-related Instructions/Decisions" ([Investigator] Reference Form 1) (if the decision made by the institutional review board is not consistent with the instructions given by the head of the institution).

[2] Action taken: Provide a specific but brief description of the action taken (including the necessary information to identify the amended protocol to be attached as appropriate [date of preparation and/or version number]).

[3] If the head of the institution confirms that the instruction provided in the field for the condition/reason for "Approval with modifications" has been appropriately followed, there is usually no need to reconsider it at an institutional review board meeting. For handling, the standard operating procedures of each institution should be followed.

(Investigator) Form 8 (Report concerning Protocol Deviations to Eliminate Immediate Hazards)

[1] Reason for the deviation: In addition to the reason for the deviation, provide a specific but brief description of the actions taken against the deviation and the preventive measures. If a document is attached as appropriate, the necessary information to identify the document (e.g., name of the document, date of preparation, and version number) should also be provided.

[2] According to GCP, other deviations than those reported in (Investigator) Form 8 should be recorded by the investigator or the subinvestigator. Such a record may be confirmed by the medical record or other equivalent documents, and it is not necessary to prepare a separate specific document for these records.

(Investigator) Form 10 (Clinical Trial-related Change Application Form)

[1] Document, etc. subject to the change:

- Mark each applicable item.
- If the addition or removal of subinvestigators affects the trial organization, application for changes using (Investigator) Form 10 will be required. It is not necessary to apply for changes in case of changes that do not affect the trial organization (change of department/title or name).

[2] Description of the change: Provide a specific but brief description of the change.

[3] Attached documents: Provide the necessary information to identify the attached document (e.g., name of the document, date of preparation, and version number).

(Investigator) Form 11 (Clinical Trial Progress Report)

[1] No. of subjects enrolled in the trial: For clinical trials of drugs, the number of subjects receiving the

investigational product should be provided. For clinical trials of medical devices, the number of subjects using the investigational device should be provided. For clinical trials of regenerative medical products, the number of subjects using the investigational product should be provided. If cell or tissue samples were collected to manufacture the investigational product, these subjects should also be included. In addition, the number of subjects who received the investigational product/used the investigational device or investigational product and completed or discontinued the trial should be provided in the parentheses. If an additional explanation is necessary regarding the number of subjects enrolled in the trial, it should be provided in the "Others" field in the "Progress of the clinical trial" section.

[2] Progress of the clinical trial: A brief description of safety and compliance with GCP should mainly be provided. In the absence of serious adverse events and protocol deviations worth mentioning, the number of subjects with adverse events and safety assessment, the number of protocol deviation to eliminate immediate hazards, and results of GCP compliance assessment should typically be provided in short form.

Serious Adverse Event Report

[1] (Investigator) Form 12 should be used for clinical trials of drugs.

[2] (Investigator) Form 14 should be used for clinical trials of medical devices.

[3] (Investigator) Form 19 should be used for clinical trials of regenerative medical products.

[4] In all cases of [1] to [3] above, an applicable form for detailed description should be used to report the status of the subject who has experienced a serious adverse event.

[5] If more than one serious adverse event or malfunction that may cause a serious adverse event is observed, a separate form should be prepared for each event/malfunction.

[6] For trials of combination products, forms to be used should be defined in advance based on the agreement between the sponsor-investigator, the institutional review board, and the institution. If there is not a particular reason, the table below should be followed. In the table below, "(Investigator)" of each form name is omitted. The term "malfunction" in the table refers to a malfunction that may cause a serious adverse event (including the case that an adverse event has actually occurred).

<When the investigational product/device is used alone (i.e., it is not a study of a combination product)>

Drug	Medical device	Regenerative medical product	Serious Adverse Event	Malfunction	Form 12	Form 14	Form 19	Form for detailed description
○			Yes	Not applicable	Required			Required
	○		Yes	No		Required		Required
	○		Yes	Yes		Required		Required
	○		No	Yes		Required		Not required
		○	Yes	No			Required	Required
		○	Yes	Yes			Required	Required
		○	No	Yes			Required	Not required

<In case of a study of a combination product>

Drug	Medical device	Regenerative medical product	Serious Adverse Event	Malfunction	Form 12	Form 14	Form 19	Form for detailed description

○	○		Yes	No	Required	Required		Required
○	○		Yes	Yes	Required	Required		Required
○	○		No	Yes	Required	Required		Not required
○		○	Yes	No	Required		Required	Required
○		○	Yes	Yes	Required		Required	Required
○		○	No	Yes	Required		Required	Not required
	○	○	Yes	No		Required	Required	Required
	○	○	Yes	Yes (Device/ Regenerative)		Required	Required	Required
	○	○	No	Yes (Device/ Regenerative)		Required	Required	Not required
○	○	○	Yes	No	Required	Required	Required	Required
○	○	○	Yes	Yes (Device/ Regenerative)	Required	Required	Required	Required
○	○	○	No	Yes (Device/ Regenerative)	Required	Required	Required	Not required

If updated information is obtained, a follow-up report should only be prepared for applicable forms.

(Investigator) Form 12 (Serious Adverse Event Report [For Clinical Trials of Drugs])

[1] Title: Clarify how many times the adverse event has been reported.

[2] Information concerning the individual experiencing the serious adverse event: Either the date of birth (year only or month and year only are also acceptable) or age should be provided based on the information provided in the Case Report Form for the clinical trial. The date of menstruation before the onset of the serious adverse event should be provided if required.

[3] Information concerning the serious adverse event: The availability of detailed information should be selected. If "Yes," provide the necessary information in the form for the detailed description defined in the notification (Standard Forms). Mark "No" if detailed information is not available because it is the initial report.

[4] Information concerning the serious adverse event: Expectedness of event with respect to the investigational product: The expectedness should be assessed based on information provided in the Investigator's Brochure. If the event is consistent with information provided in the Investigator's Brochure in terms of the nature and severity, the event should be considered as "expected." If the event is not consistent with information provided in the Investigator's Brochure in terms of the nature and severity (e.g., acute renal failure vs "interstitial nephritis" and hepatitis vs "fulminant hepatitis"), the event should be considered "unexpected."

[5] Information concerning the serious adverse event: Date of event onset: Provide the date of onset of the reported adverse event.

[6] Information concerning the serious adverse event: Reason why event was determined to be serious: Provide the date when the reported event was determined to be serious, and mark the applicable reason. More than one reason may be selected.

[7] Information concerning the investigational product: Investigational product: For blinded treatment, mark "Test product (blinded)." For the test drug, mark "Test product." For the comparator, mark "Others." Provide the name of the drug if known.

[8] Causal relationship with the event: Assess the causal relationship according to Article 2-15 (10) of the GCP Guidance for Drugs.

[9] Information concerning the investigational product: Action taken after event onset: If treatment with the investigational product has already been completed at event onset, mark "Not applicable."

[10] Remarks: For clinical trials of combination products, it should be clarified that there are other report forms related to this report. These report forms are identified by the type of form, subject identification code, serious adverse event term, malfunction term, number of reports, and date of report.

(Investigator) Form 14 (Serious Adverse Event and Malfunction Report [For Clinical Trials of Medical Devices])

[1] Title: Clarify how many times the adverse event has been reported.

[2] Depending on whether it is a serious adverse event or a malfunction that may cause a serious adverse event (including the case that an adverse event has actually occurred), mark either as applicable according to the table below:

<table>
<tr><th>Serious adverse event</th><th>Yes</th><th>Yes</th><th>No</th></tr>
<tr><th>Malfunction*</th><th>Yes</th><th>No</th><th>Yes</th></tr>
<tr><td rowspan="2">Check of the first sentence</td><td>■Adverse event determined to be serious</td><td>■Adverse event determined to be serious</td><td>☐Adverse event determined to be serious</td></tr>
<tr><td>■Malfunction that may cause a serious adverse event</td><td>☐Malfunction that may cause a serious adverse event</td><td>■Malfunction that may cause a serious adverse event</td></tr>
<tr><td>Information concerning the individual experiencing the serious adverse event, etc.</td><td colspan="3">Note: Fill out according to precautions [3] to [4] to complete (Investigator) Form 14.</td></tr>
<tr><td rowspan="3">Information concerning the serious adverse event
Check of the availability of detailed information</td><td colspan="2">If no detailed information is available because it is the initial report:
☐Available (Standard Forms) ■Not available ☐Not applicable</td><td rowspan="3">☐Yes (Standard Forms)
☐No
■Not applicable

Note: Do not fill out this field.</td></tr>
<tr><td colspan="2">If detailed information is available: The designated form for a detailed description is used.
■Available (Standard Form) ☐Not available ☐Not applicable</td></tr>
<tr><td colspan="2">Note: Fill out according to precautions [5] to [7] to complete (Investigator) Form 14.</td></tr>
<tr><td>Information concerning the investigational device (including procedures)</td><td colspan="3">Note: Fill out according to precautions [8] to [11] to complete (Investigator) Form 14.</td></tr>
<tr><td>Causal relationship with the event</td><td colspan="2">(Assess the causal relationship without selecting “Not applicable.”)</td><td>■Not applicable</td></tr>
<tr><td>Action taken against the event caused by the investigational device</td><td colspan="2">(Check whether action was taken)</td><td>■Not applicable</td></tr>
<tr><td>Check of information concerning the investigational device malfunction</td><td>☐Not applicable
Note: Fill out according to precautions [12] to [14] to complete (Investigator) Form 14.</td><td>■Not applicable
Note: Do not fill out this field.</td><td>☐Not applicable
Note: Fill out according to precautions [12] to [14] to complete (Investigator) Form 14.</td></tr>
</table>

*: The term “malfunction” refers to a malfunction that may cause a serious adverse event (including the case that an adverse event has actually occurred).

[3] Information concerning the individual experiencing the serious adverse event, etc.: Either the date of birth (year only or month and year only are also acceptable) or age should be provided based on the information provided in the Case Report Form for the clinical trial. The date of menstruation before the onset of the serious adverse event should be provided if required.

[4] If the subject cannot be identified because the device malfunction has occurred before the investigational device has been used, the field for the subject identification code should be filled out as “not applicable,” mark “Others” in the field for the category of the individual experiencing the serious adverse event in the section of information concerning the individual experiencing the serious adverse event, etc. and specify

as “not applicable.”

[5] Information concerning the serious adverse event: Expectedness of event with respect to the investigational device: The expectedness should be assessed based on information provided in the Investigator’s Brochure. If the event is consistent with information provided in the Investigator’s Brochure in terms of the nature and severity, the event should be considered as “expected.” If the event is not consistent with information provided in the Investigator’s Brochure in terms of the nature and severity (e.g., acute renal failure vs “interstitial nephritis” and hepatitis vs “fulminant hepatitis”), the event should be considered “unexpected.”

[6] Information concerning the serious adverse event: Date of event onset: Provide the date of onset of the reported adverse event.

[7] Information concerning the serious adverse event: Date when event was determined to be serious: Reason why event was determined to be serious: Provide the date when the reported event was determined to be serious, and mark the applicable reason. More than one reason may be selected.

[8] Information concerning the investigational device (including procedures): Investigational device, etc.: For blinded treatment, mark “Test device (blinded).” For the test device, mark “Test device.” For the comparator or accessories, mark “Others.” As for the status of blinding, additional information should be provided in the “Description of the investigational device malfunction” or “Remarks” field in the “Information concerning the investigational device malfunction” section. As for the lot number, the lot or serial number of the investigational device should be provided.

[9] Information concerning the investigational device (including procedures): Date/duration of use: For a procedure, the date of completion should be provided. For the investigational device, the duration of use should be provided. If completed, mark the field for the date to enter the specific date. If currently performed or used, mark the applicable one without entering the date. If the investigational device has not been removed from the subject’s body, mark “Currently in use.” If the malfunction has occurred at a time when the procedure was not performed or the device was not used, it is not necessary to enter the date. If additional information concerning the investigational device is required, specify it in the “Description of the investigational device malfunction” or the “Remarks” field in the “Information concerning the investigational device malfunction, etc.” section.

[10] Information concerning the investigational device (including procedures): Causal relationship with the event: Regarding the causal relationship between the adverse event and the procedure/investigational device, mark the applicable one. If there are no adverse events to be reported or no procedures were performed, mark “Not applicable.”

[11] Information concerning the investigational device (including procedures): Action taken against the event caused by the investigational device: Regarding action taken after the onset of the adverse event, mark “Yes” or “No.” Detailed information concerning the action taken should be provided in the “Information concerning the investigational device malfunction” section. If there are no adverse events to be reported or no procedures were performed, mark “Not applicable.”

[12] Information concerning the investigational device malfunction: Provide information concerning the investigational device malfunction. If there are no malfunctions, mark “Not applicable.”

[13] Information concerning the investigational device malfunction: Date of onset of the investigational device malfunction: In field for the “date of onset of the investigational device malfunction,” the time should also be entered as appropriate.

[14] Information concerning the investigational device malfunction: Possible cause of the investigational device malfunction: Select the presence or absence of the cause in the applicable field. If "Yes," specify.

[15] Reason for considering that the investigational device malfunction may cause a serious adverse event: This field should be filled out regardless of the presence or absence of a serious adverse event.

[16] Remarks: For clinical trials of combination products, it should be clarified that there are other report forms related to this report. These report forms are identified by the type of form, subject identification code, serious adverse event term, malfunction term, number of reports, and date of report. Other comments, if any, should also be provided.

(Investigator) Form 16 (Safety Information Report)

[1] Outline of the safety information (upper part): If an individual case report concerning an unexpected adverse drug reaction is submitted, mark all applicable items.

[2] Outline of the safety information (lower part): If an annual report, a research report, or a safety measure report is submitted, mark all applicable items.

[3] Sponsor-investigator's opinion: Mark each applicable item.

[4] Attached documents: Provide the necessary information to identify an attached document (e.g., name of the document, date of preparation, and version number).

[5] Remarks: Provide any information worth noting.

[6] If agreed in advance between the sponsor-investigator, the institutional review board, and the head of the institution, the sponsor-investigator may simultaneously submit the form to the institutional review board, in addition to the head of the institution. In this case, it may be regarded that the head of the institution has provided the institutional review board with the necessary written information, and it is therefore not necessary to prepare (Investigator) Form 4.

[7] If the coordinating investigator or coordinating committee collects information and provide it to the sponsor-investigators, each sponsor-investigator will not need to submit the form to investigators of other institutions.

(Investigator) Form 17 (Clinical Trial Completion [Premature Termination/Suspension] Report)

[1] Checkboxes for "Completed", "Prematurely Terminated", and "Suspended": Mark each applicable item.

[2] No. of subjects enrolled in the trial: For clinical trials of drugs, the number of subjects receiving the investigational product should be provided. For clinical trials of medical devices, the number of subjects using the investigational device should be provided. For clinical trials of regenerative medical products, the number of subjects using the investigational product should be provided. If cell or tissue samples were collected to manufacture the investigational product, these subjects should also be included. If an additional explanation is necessary regarding the number of subjects enrolled in the trial, it should be provided in the "Others" field in the "Overview of clinical trial results, etc." section.

[3] Overview of clinical trial results, etc.: If there is not enough space for the description, an attachment may be used. In this case, the field in the form should be filled out as "See the attachment."

(Investigator) Form 18 (Development Discontinuation Report)

[1] In case of "Obtainment of marketing approval" or "Notification of results of reexamination" in the "Information reported" section, the reportability to the institutional review board will be determined by

discussion between the head of the institution and the institutional review board.

[2] Document retention, etc.: Mark the applicable item, and provide the necessary information.

(Investigator) Form 19 (Serious Adverse Event and Malfunction Report [For Clinical Trials of Regenerative Medical Products])

[1] Title: Clarify how many times the adverse event has been reported.

[2] Depending on whether it is a serious adverse event or a malfunction that may cause a serious adverse event (including the case that an adverse event has actually occurred), provide either applicable one according to the table below:

<table>
<tr><th>Serious adverse event</th><th>Yes</th><th>Yes</th><th>No</th></tr>
<tr><th>Malfunction*</th><th>Yes</th><th>No</th><th>Yes</th></tr>
<tr><td rowspan="2">Check of the first sentence</td><td>■Adverse event determined to be serious</td><td>■Adverse event determined to be serious</td><td>☐Adverse event determined to be serious</td></tr>
<tr><td>■Malfunction that may cause a serious adverse event</td><td>☐Malfunction that may cause a serious adverse event</td><td>■Malfunction that may cause a serious adverse event</td></tr>
<tr><td>Information concerning the individual experiencing the serious adverse event, etc.</td><td colspan="3">Note: Fill out according to precautions [3] to [4] to complete (Investigator) Form 19.</td></tr>
<tr><td rowspan="4">Information concerning the serious adverse event Check of the availability of detailed information</td><td colspan="2">If no detailed information is available because it is the initial report:
☐Available (☐Standard Forms ☐Other forms) ■Not available ☐Not applicable</td><td rowspan="4">☐Yes (☐Standard Form ☐Other forms)
☐No
■Not applicable

Note: Do not fill out this field.</td></tr>
<tr><td colspan="2">If detailed information is available: The designated form for a detailed description is used.
■Available (■Standard Forms ☐Other forms) ☐Not available ☐Not applicable</td></tr>
<tr><td colspan="2">If detailed information is available: Non-designated forms are used.
■Available (☐Standard Forms ■Other forms) ☐Not available ☐Not applicable</td></tr>
<tr><td colspan="2">Note: Fill out according to precautions [5] to [7] to complete (Investigator) Form 19.</td></tr>
<tr><td>Information concerning the investigational product (including procedures)</td><td colspan="3">Note: Fill out according to precautions [8] to [11] to complete (Investigator) Form 19.</td></tr>
<tr><td>Causal relationship with the event</td><td colspan="2">(Assess the causal relationship without selecting “Not applicable.”)</td><td>■Not applicable</td></tr>
<tr><td>Action taken against the event caused by the investigational product</td><td colspan="2">(Check whether action was taken or not.)</td><td>■Not applicable</td></tr>
<tr><td>Check of information concerning the investigational product malfunction</td><td>☐Not applicable
Note: Fill out according to precautions [12] to [14] to complete (Investigator) Form 19.</td><td>■Not applicable
Note: Do not fill out this field.</td><td>☐Not applicable
Note: Fill out according to precautions [12] to [14] to complete (Investigator) Form 19.</td></tr>
</table>

*: The term “malfunction” refers to a malfunction that may cause a serious adverse event (including the case that an adverse event has actually occurred).

[3] Information concerning the individual experiencing the serious adverse event, etc.: Either the date of birth (year only or month and year only are also acceptable) or age should be provided based on the information provided in the Case Report Form for the clinical trial. The date of menstruation before the onset of the serious adverse event should be provided if required.

[4] If the subject cannot be identified because the product malfunction has occurred before the investigational product has been used, the field for the subject identification code should be filled out as “not applicable,” mark “Others” in the field for the category of the individual experiencing the serious adverse event in the section of information concerning the individual experiencing the serious adverse event, etc. and specify as “not applicable.”

[5] Information concerning the serious adverse event: Expectedness of event with respect to the investigational product: The expectedness should be assessed based on information provided in the Investigator's Brochure. If the event is consistent with information provided in the Investigator's Brochure in terms of the nature and severity, the event should be considered as "expected." If the event is not consistent with information provided in the Investigator's Brochure in terms of the nature and severity (e.g., acute renal failure vs "interstitial nephritis" and hepatitis vs "fulminant hepatitis"), the event should be considered "unexpected."

[6] Information concerning the serious adverse event: Date of event onset: Provide the date of onset of the reported adverse event.

[7] Information concerning the serious adverse event: Reason why event was determined to be serious: Provide the date when the reported event was determined to be serious, and mark the applicable reason. More than one reason may be selected.

[8] Information concerning the investigational product (including procedures): Investigational product, etc.: For blinded treatment, mark "Test product (blinded)." For the test product, mark "Test product." For the comparator or accessories, mark "Others." As for the status of blinding, additional information should be provided in the "Description of the investigational product malfunction" or "Remarks" field in the "Information concerning the investigational product malfunction" section. As for the lot number, the lot or serial number of the investigational product should be provided.

[9] Information concerning the investigational product (including procedures): Date/duration of use: For a procedure, the date of completion should be provided. For the investigational product, the duration of use should be provided. If completed, mark the field for the date to enter the specific date. If currently performed or used, mark the applicable one without entering the date. If the investigational product has not been removed from the subject's body, mark "Currently in use." If the malfunction has occurred at a time when the procedure was not performed or the product was not used, it is not necessary to enter the date. If additional information concerning the investigational product is required, specify it in the "Description of the investigational product malfunction" or the "Remarks" field in the "Information concerning the investigational product malfunction" section.

[10] Information concerning the investigational product (including procedures): Causal relationship with the event: Regarding the causal relationship between the adverse event and the procedure/investigational product, mark the applicable one. If there are no adverse events to be reported or no procedures were performed, mark "Not applicable."

[11] Information concerning the investigational product (including procedures): Action taken against the event caused by the investigational product: Regarding action taken after the onset of the adverse event, mark "Yes" or "No." Detailed information concerning the action taken should be provided in the "Information concerning the investigational product malfunction" section. If there are no adverse events to be reported or no procedures were performed, mark "Not applicable."

[12] Information concerning the investigational product malfunction: Provide information concerning the investigational product malfunction. If there are no malfunctions, mark "Not applicable."

[13] Information concerning the investigational product malfunction: Date of onset of the investigational product malfunction: In field for the "date of onset of the investigational product malfunction," the time should also be entered as appropriate.

[14] Information concerning the investigational product malfunction: Possible cause of the investigational

product malfunction: Select the presence or absence of the cause in the applicable field. If "Yes," specify.

[15] Reason for considering that the investigational product malfunction may cause a serious adverse event: This field should be filled out regardless of the presence or absence of a serious adverse event.

[16] Remarks: For clinical trials of combination products, it should be clarified that there are other report forms related to this report. These report forms are identified by the type of form, subject identification code, serious adverse event term, malfunction term, number of reports, and date of report. Other comments, if any, should also be provided.

Form for detailed description (Attachment forms common to Forms 12, 14, and 19)

[1] In the event of a serious adverse event, these forms should be attached to Forms 12, 14 and 19.

[2] Medications used at the onset of the serious adverse event: If the dosage regimen is changed, the duration of treatment should be clarified (new fields may be used).

[3] Clinical course: Enter the date of onset of the reported adverse event, the date when it was determined to be serious, and the outcome of the event, and clearly provide the duration of the event. If treatment is blinded, the status of unblinding should be provided in addition to the information required in each field.

[4] If a serious adverse event occurs only in an offspring/fetus, information concerning the subject (parent) should be provided. If a serious adverse event occurs in the subject, page 4 of the form does not have to be completed.

(Investigator) Reference Form 1 (Notification of Clinical Trial-related Instructions/Decisions)

[1] (Investigator) Reference Form 1 should be used if the decision made by the institutional review board is not consistent with the instructions given by the head of the institution in the "Clinical Trial Review Results Notification" ([Investigator] Form 5).

[2] Review items (Review documents): Mark each applicable item.

[3] Handling: Mark the applicable item.

[4] Condition of/reason for the "handling": Provide a specific but brief description.

(Investigator) Reference Form 2 (Source Document Verification Application Form)

[1] Generally, a specific form therefore does not have to be submitted each time source document verification is performed. However, a certain form of guarantee is necessary to avoid misunderstanding of the date of source document verification and other related information. When such a guarantee is provided in writing, (Investigator) Reference Form 2 should be used. For the abovementioned reason, since (Investigator) Reference Form 2 is handled between individuals who are directly involved in source document verification, the addressee of the form is the institution's secretariat, and the sender of the form is the individual to perform the source document verification (or a representative if there is more than one individual performing source document verification). (Investigator) Reference Form 2 is not subject to review or reporting by the institutional review board.

[2] Contact information of the person performing source document verification: If more than one individual visits the institution for source document verification, information of a representative (the source document verification applicant) should be provided. If the institution needs to know in advance who will perform source document verification for any particular reason (e.g., direct access to electronic medical charts), information concerning all individuals to be involved in source document verification (the

necessary information, such as name and department) should be provided in the “Remarks” field. Although the form has fields for phone and fax numbers and E-mail address as the means of communication, only the one actually used as the means of communication with the institution should be filled out.

[3] Witness (If applicable): Mark each applicable item. If “Subinvestigator,” “Trial staff member,” or “Others” is marked, the necessary information to identify the witness (e.g., name) should be provided in the “Remarks” field.

[4] Subject identification code: If the document subject to source document verification is the same, more than one code or a range of codes (e.g., XX-1 to XX-20) should be provided in the single field.

[5] Contact information of the person in charge of the Clinical Trial Secretariat (contact point): Although the form has fields for phone and fax numbers and E-mail address as the means of communication, only the one actually used as the means of communication with the individual performing the source document verification should be filled out.