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SOP # Version	Title	Effective Date
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N/A	Glossary of Terms	14-Apr-2026
N/A	References	14-Apr-2026

Title	Authority and Purpose
SOP Code	101.005
Effective Date	14-Apr-2026

Site Approvals

Name and Title (typed or printed)	Signature	Date dd/Mon/yyyy

1.0 PURPOSE

The purpose of this standard operating procedure (SOP) is to:

1. State the organizational authority under which the Research Ethics Board (REB) is established and empowered;
2. Define the purpose of the REB;
3. State the principles governing the REB to assure that the rights and welfare of Participants are protected;
4. State the authority of the REB.

2.0 SCOPE

This SOP pertains to REBs that review human Participant research in compliance with applicable regulations and policies.

3.0 RESPONSIBILITIES

The responsible official(s), all REB members and REB Office Personnel, are responsible for ensuring that the requirements of this SOP are met.

4.0 DEFINITIONS

See Glossary of Terms.

5.0 PROCEDURE

The REB will maintain and follow all written policies and procedures consistent with federal and provincial regulations, good clinical practices, and ethics policies when reviewing proposed research.

5.1 Statement of Organizational Authority

5.1.1 The organization has authorized the REB to review research involving human Participants conducted under the auspices of the organization;

5.1.2 The REB is established and empowered under the authority of the organization. The organization requires that all research involving human Participants be reviewed and approved by an REB prior to initiation of any research related activities.

5.2 Purpose of the REB

5.2.1 The REB's purpose is to protect the rights and welfare of human Participants participating in research;

5.2.2 The REB reviews and oversees the research to ensure that it meets ethical principles and that it complies with all applicable regulations and policies pertaining to human Participant protection

These include, but are not limited to:

- The *Food and Drugs Act* and applicable *Regulations*
- The International Council for Harmonization Good Clinical Practice (ICH E6(R3) Guidelines (2025), which emphasize a proportionate, risk-based approach to trial conduct and oversight,
- The Declaration of Helsinki: Ethical Principles for Medical Research Involving Human Subjects, the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans, and where applicable,
- US Federal Regulations.

For research funded or regulated by U.S. agencies, Canadian REBs may be required to comply with applicable U.S. federal regulations, such as the Common Rule (45 CFR 46) and FDA regulations (21 CFR Parts 50 and 56), to the extent they do not conflict with Canadian law and policy.

5.3 Governing Principles

5.3.1 The REB is guided by the ethical principles regarding all research involving human Participants including:

- Respect for Persons:
  - Recognize the intrinsic value of human beings and the respect and consideration they are due,
  - Incorporate moral obligations to respect autonomy and to protect those with developing, impaired or diminished autonomy.
- Concern for Welfare:
  - Aim to protect the welfare of Participants, and, in some circumstances, to promote that welfare in view of any foreseeable risks,
  - Provide Participants with enough information to be able to adequately assess risks and potential benefits associated with their participation,
  - Ensure that Participants are not exposed to unnecessary risks.
- Justice:
  - Obligation to treat people fairly with equal respect and concern,
  - Vulnerable or marginalized people may need to be afforded special attention.

5.4 REB Authority

5.4.1 The REB is established to review all research involving human Participants within its established jurisdiction;

5.4.2 The REB has the authority to ensure that all research conducted under its oversight is designed and conducted in such a manner that it protects the rights, welfare, and privacy of research Participants.

Specifically, the REB has the authority to:

- establish the ethics review processes, and provide research ethics oversight to ensure the ethical conduct of the research,
- approve, require modifications to, or disapprove, any research activity that falls within its jurisdiction,
- ensure that the researcher has policies and procedures to protect the rights, safety and welfare of research Participants,
- request, receive and share any information involving the research that the REB considers necessary to fulfil its mandate, while maintaining confidentiality and respecting privacy,
- conduct continuing ethical review to protect the rights and welfare and privacy of research Participants,
- suspend or terminate the ethics approval for the research,
- place restrictions on the research,
- take any actions considered reasonably necessary, and consistent with policies and procedures, to ensure the protection of the rights, safety, and well-being of Participants in research conducted under the REB's jurisdiction.

5.5 Research Subject to US Regulations

The REB shall apply the requirements of the applicable US regulations to the extent that they vary from the protections set out in the applicable Canadian regulations and policies.

6.0 REFERENCES

See References.

7.0 REVISION HISTORY

SOP Code	Effective Date	Summary of Changes
SOP101.001	15-Sept-2014	Original version
SOP101.002	08-Mar-2016	No revisions needed
SOP101.003	08-Oct-2019	5.2.3: ICH 'Conference' changed to 'Council'; Removed "Research ethics oversight of biomedical clinical trials (CAN/CGSB-191.1-2013)
SOP101.004	15-May-2023	No revisions needed
SOP101.005	14-Apr-2026	2.0: revised 'guidelines' to 'policies'. 5.2.3: added text to reflect ICH E6(R3) proportionate review principles, and clarification of U.S. Common Rule (45 CFR 46) and FDA regulations (21 CFR Parts 50 and 56) applicability where required.

SOP 102.005

Title	Research Requiring REB Review
SOP Code	102.005
Effective Date	14-Apr-2026

Site Approvals

Name and Title (typed or printed)	Signature	Date dd/Mon/yyyy

1.0 PURPOSE

The purpose of this standard operating procedure (SOP) is to describe research activities that require Research Ethics Board (REB) review and research activities that do not.

2.0 SCOPE

This SOP pertains to REBs that review human Participant research in compliance with applicable regulations and policies.

3.0 RESPONSIBILITIES

All REB members and REB Office Personnel are responsible for ensuring that the requirements of this SOP are met.

4.0 DEFINITIONS

See Glossary of Terms.

5.0 PROCEDURE

All research involving human Participants must be reviewed and approved by an REB. No intervention or interaction with human Participants in research, including recruitment, may begin until an REB has reviewed and approved the research protocol and related attachments.

5.1 Research that Requires REB Review

The following requires ethics review and approval by an REB before the research commences:

(a) Research involving living human Participants,

(b) Research involving human biological materials, as well as human embryos, fetuses, fetal tissue, reproductive materials, and stem cells. This applies to materials derived from living and deceased individuals.

5.2 Research Exempt from REB Review

5.2.1 Research that relies exclusively on publicly available information does not require REB review when:

(a) The information is legally accessible to the public and appropriately protected by law,

(b) The information is publicly accessible and there is no reasonable expectation of privacy;

5.2.2 REB review is not required for research involving the observation of people in public places where:

(a) It does not involve any intervention staged by the Researcher, or direct interaction with the individuals or groups,

(b) Individuals or groups targeted for observation have no reasonable expectation of privacy, and

(c) Any dissemination of research results does not allow identification of specific individuals;

5.2.3 REB review is not required for research that relies exclusively on secondary use of anonymous information, or anonymous human biological materials-, so long as the process of data linkage or recording or dissemination of results does not

generate identifiable information;

5.2.4 The opinion of the REB should be sought whenever there is any doubt about the applicability of the guidelines and regulations.

5.3 Activities Not Requiring REB Review

5.3.1 Research activities outside the scope of REB expertise and review may still raise ethical issues that would benefit from careful consideration by an individual or body capable of providing independent guidance, other than an REB;

5.3.2 Quality assurance and quality improvement studies, program evaluation activities, performance reviews, or testing within normal educational requirements when used exclusively for assessment, management or improvement purposes, do not constitute research for the purposes of this SOP, and do not fall within the scope of REB review;

5.3.3 Creative practice activities, in and of themselves, do not require REB review. However, research that employs creative practice to obtain responses from Participants that will be analyzed to answer a research question is subject to REB review.

6.0 REFERENCES

See References.

7.0 REVISION HISTORY

SOP Code	Effective Date	Summary of Changes
SOP102.001	15-Sept-2014	Original version
SOP102.002	08-Mar-2016	No revisions needed
SOP102.003	08-Oct-2019	No revisions needed
SOP102.004	15-May-2023	No revisions needed
SOP102.005	14-Apr-2026	2.0: revised ‘guidelines’ to ‘policies’. 5.0: revised ‘consent documents and recruitment materials’ to ‘related attachments’ to reflect the scope of materials which may be reviewed and approved by an REB. 5.3.1: deleted ‘some’ in front of ‘independent guidance’.

SOP 103.005

Title	Training and Education
SOP Code	103.005
Effective Date	14-Apr-2026

Site Approvals

Name and Title (typed or printed)	Signature	Date dd/Mon/yyyy

1.0 PURPOSE

This standard operating procedure (SOP) describes the training and education requirements for Research Ethics Board (REB) members and REB Office Personnel.

2.0 SCOPE

This SOP pertains to REBs that review human Participant research in compliance with applicable regulations and policies.

3.0 RESPONSIBILITIES

All REB members and REB Office Personnel are responsible for ensuring that the requirements of this SOP are met.

4.0 DEFINITIONS

See Glossary of Terms.

5.0 PROCEDURE

REB members, REB Office Personnel, and others charged with the responsibility for reviewing, approving, and overseeing human Participant research should be well-versed in the regulations, guidelines, policies, and ethical principles applicable to human Participant research. Adequate training and education in these areas is critical for the REB to fulfill its mandate to protect the rights and welfare of research Participants in a consistent manner.

5.1 Training and Education – REB Members

5.1.1 The REB Chair or Designee will provide new REB members with a general overview of the policies and procedures pertinent to REB meeting functions and REB member expectations, as well as an orientation to the principles and guidelines for research ethics;

5.1.2 New REB members will receive an orientation before beginning their formal duties. REB members are required to complete the TCPS2 online tutorial and are expected to participate in the orientation process which may include, but are not limited to:

- Background on the REB (e.g., Terms of Reference, governance structure, annual reports, process flowchart),
- Policies and Procedures (e.g., relevant SOPs and associated forms, consent form template, consent form checklist),
- Member information (e.g., meeting schedule, membership list, information and guidelines for members, reviewer guide),
- Regulatory and guidance documents,
- Other member-specific information (e.g., copy of signed confidentiality and conflict of interest agreement, membership appointment letter),
- Resource information (e.g., list of training and education references, relevant articles, etc.);

5.1.3 As part of their orientation, new REB members will be offered the opportunity to observe at least one REB meeting prior to commencing their REB member duties;

5.1.4 REB members are encouraged to attend conferences and other educational sessions pertaining to human Participant research protection, such as the Canadian Association of Research Ethics Board (CAREB) annual general meeting and CAREB regional meetings. The REB office will support such activities to the extent possible and as appropriate to the responsibilities of REB members. Conference attendance is based on availability of funding and other practical considerations (e.g., timing, conference location);

5.1.5 Ongoing ethics education in areas germane to the REB members' responsibilities may be provided at REB meetings;

5.1.6 New or revised policies and SOPs will be disseminated to the new REB members;

5.1.7 REB members are encouraged to engage in self-directed learning in research ethics and in the conduct of research to enhance their ability to fulfill their responsibilities.

5.2 Training and Education – REB Office Personnel

5.2.1 The REB Chair or Designee will provide new REB Office Personnel with an overall orientation to the REB including a general overview of the policies and procedures pertinent to their role in support of the REB;

5.2.2 New REB Office Personnel will receive an orientation package. Before commencing their official duties in the REB office, REB Office Personnel are expected to read and become familiar with the information;

5.2.3 New REB Office Personnel will receive training on the REB SOPs and will be expected to be knowledgeable and compliant with the SOPs;

5.2.4 New REB Office Personnel are required to complete the TCPS2 online tutorial, and are encouraged to complete additional and ongoing relevant education and training in research ethics and in the conduct of research;

5.2.5 REB Office Personnel are encouraged to attend conferences and educational sessions pertaining to human Participant research protection, such as the CAREB annual general meeting and CAREB regional meetings. The REB office will support such activities to the extent possible and as appropriate to the responsibilities of the REB Office Personnel. Conference attendance is based on availability of funding and other practical considerations (e.g., workload, staffing, conference location);

5.2.6 New or revised policies and SOPs will be disseminated to the REB Office Personnel;

5.2.7 REB Office Personnel are encouraged to engage in self-directed learning to enhance their ability to fulfill their responsibilities.

5.3 Documentation of Training and Education

5.3.1 The REB office will retain copies of the CVs of all REB members and REB Office Personnel;

5.3.2 REB members and REB Office Personnel will record their relevant training and education and provide copies of their certificates of completion. Training records will be kept on file in the REB office;

5.3.3 REB members and REB Office Personnel are encouraged to retain copies of agendas of relevant workshops, seminars and conferences attended;

5.3.4 REB agendas and minutes will record the distribution of any educational materials presented at the REB meetings.

6.0 REFERENCES

See references

7.0 REVISION HISTORY

SOP Code	Effective Date	Summary of Changes
SOP103.001	15-Sept-2014	Original version
SOP103.002	08-Mar-2016	No revisions needed
SOP103.003	08-Oct-2019	5.1.4: deletion of reference to REB office personnel 5.2.5: deletion of reference to REB members
SOP103.004	15-May-2023	No revisions needed
SOP103.005	14-Apr-2026	2.0 revised ‘guidelines’ to ‘policies’.

Title	Management of REB Office Personnel
SOP Code	104.005
Effective Date	14-Apr-2026

Site Approvals

Name and Title (typed or printed)	Signature	Date dd/Mon/yyyy

1.0 PURPOSE

This standard operating procedure (SOP) describes the overall management of the Research Ethics Board (REB) Office Personnel.

2.0 SCOPE

This SOP pertains to REBs that review human Participant research in compliance with applicable regulations and policies.

3.0 RESPONSIBILITIES

The organizational officials, REB Chair or Designee and REB Office Personnel are responsible for ensuring that the requirements of this SOP are met. The organization is responsible for providing sufficient resources to adequately support the functions of the REB.

4.0 DEFINITIONS

See Glossary of Terms.

5.0 PROCEDURE

The REB Office Personnel provides consistency, expertise, and administrative support to the REB, and serves as a daily link between the REB and the research community. The REB Office Personnel are vital to ensuring the efficient and effective administration and enforcement of REB decisions; thus the highest level of professionalism and integrity is expected.

The organization shall ensure that REB Office Personnel possess appropriate qualifications, training, and experience, and that staffing levels are proportionate to the complexity and volume of research under review.

5.1 Job Descriptions

5.1.1 Job descriptions will be developed to establish the role requirements for the REB Office Personnel, in accordance with organizational policies and procedures;

5.1.2 Each REB Office Personnel will be provided with a copy of his or her job description, job expectations, and access to all applicable organizational policies and procedures.

5.2 Responsibilities

5.2.1 REB Office Personnel responsibilities may include:

- the pre-review of submissions and requests to the REB,
- quality management activities,
- the management of administrative issues involving REB research ethics oversight as described by applicable REB policies,
- the implementation of REB directives, and
- the provision of advice and information to the REB.

5.3 Hiring and Terminating REB Office Personnel

5.3.1 The organization will determine responsibility for the recruitment, hiring, and termination of REB Office Personnel, in accordance with organizational policies and procedures.

5.4 Delegation of Authority or Responsibility

5.4.1 Appropriate tasks or responsibilities may be delegated to the REB Office Personnel in accordance with organizational/REB policy, if the individual has the expertise to carry out the task(s), as per applicable guidelines.

5.5 Performance Evaluations and Documentation

5.5.1 Performance feedback will be provided on an ongoing basis;

5.5.2 The organization will determine responsibility for conducting formal performance evaluations in accordance with organizational policies and procedures;

5.5.3 The organization will determine responsibility for identifying, documenting, and retaining formal REB Office Personnel interactions.

5.6 Periodic Evaluation of REB Office Human Resource Needs

5.6.1 The organization shall periodically assess REB resources to ensure effective support of REB functions;

5.6.2 The evaluation will assess whether the REB Office Personnel, equipment, finances, and space, are adequate to carry out its function in support of the REB;

5.6.3 The assessment takes into consideration the volume, complexity, and types of research projects administered by the REB Office Personnel and whether activities in support of the REB can be completed in a timely manner;

5.6.4 The need for additional resources will be discussed with the appropriate Organizational Official as appropriate.

6.0 REFERENCES

Note: references will reflect the organizational policies and practices

7.0 REVISION HISTORY

SOP Code	Effective Date	Summary of Changes
SOP104.001	15-Sept-2014	Original version
SOP104.002	08-Mar-2016	5.4.1: revised wording for delegation of responsibilities to REB Office Personnel
SOP104.003	08-Oct-2019	No revisions needed
SOP104.004	15-May-2023	No revisions needed
SOP104.005	14-Apr-2026	2.0: changed ‘guidelines’ to ‘policies’. 5.0: added “The organization shall ensure that REB Office Personnel possess appropriate qualifications, training, and experience, and that staffing levels are proportionate to the complexity and volume of

		research under review. 5.6.1: replaced ‘A periodic evaluation of the adequacy of the REB resources will be conducted’ with ‘The organization shall periodically assess REB resources to ensure effective support of REB functions.’

Title	Conflicts of Interest – REB Members and REB Office Personnel
SOP Code	105A.005
Effective Date	14-Apr-2026

Site Approvals

Name and Title (typed or printed)	Signature	Date dd/Mon/yyyy

1.0 PURPOSE

This standard operating procedure (SOP) describes real, potential, or perceived Conflicts of Interest (COI) for Research Ethics Board (REB) members (including the REB Chair and any ad hoc advisors) and REB Office Personnel. It describes the requirements and procedures for disclosure and management of COI.

2.0 SCOPE

This SOP pertains to REBs that review human Participant research in compliance with applicable regulations and policies.

3.0 RESPONSIBILITIES

All REB members and REB Office Personnel are responsible for disclosing any real, potential, or perceived COI, and for ensuring that the requirements of this SOP are met.

4.0 DEFINITIONS

See Glossary of Terms.

5.0 PROCEDURE

COI (real, potential, or perceived) arise when an individual in a position of trust has competing professional or personal interests. Such competing interests may influence their professional judgment, objectivity, and independence and can potentially influence the outcome of a decision, for personal benefit. A COI may exist even if no unethical or improper act results from the conflict.

REBs should identify and manage COI to maintain public confidence and trust and to maintain the independence and integrity of the ethics review. If a COI cannot be avoided, procedures should be in place to mitigate the conflict.

The REB must be perceived to be fair and impartial, immune from pressure either by the Sponsor, affiliated organizations, Researchers whose research is being reviewed, or by other professional and/or non-professional sources.

The standard that guides decisions about determining COI is whether an independent observer could reasonably question whether the individual's actions or decisions are based on factors other than the rights, welfare, and safety of the Participants.

5.1 REB Reviewer Assignment

5.1.1 The REB Chair or Designee reviews the agenda prior to the REB meeting to identify potential COI;

5.1.2 When the agenda is distributed, REB members are expected to disclose any conflicting interest(s) for any of the projects on the agenda as soon as possible;

5.1.3 If a member is unclear as to whether a COI exists, they must contact the REB Chair or Designee to seek clarification. The REB Chair or Designee will determine whether the circumstances should be defined as a COI and the member shall follow the REB's decision regarding any actions required to mitigate their real or perceived COI;

5.1.4 If a COI is identified in the Reviewer assignments, the project is assigned to another REB member.

5.2 Full Board Meeting

5.2.1 At the outset of the meeting, REB members are reminded of their obligation to orally disclose/declare any real, potential, or perceived COI. All declared COI will be recorded in the REB meeting minutes;

5.2.2 If a COI is declared and determined as such, the REB member may be asked to provide information about the research, but must be recused for the deliberation and decision;

5.2.3 The REB member's recusal will be recorded in the minutes, and the REB member will not be counted towards quorum.

5.2.4 If recused, the REB member must abstain from voting on/approving the minutes of that meeting.

5.3 Delegated Review

5.3.1 The REB Chair or Designee will assess projects undergoing the Delegated review process to determine potential COI;

5.3.2 REB members involved in the Delegated review process are expected to disclose any conflicting interests;

5.3.3 If a COI is identified, the project is assigned to another REB member.

5.4 REB Chair

5.4.1 In the event that the REB Chair declares a COI, the Vice-Chair or alternate REB member will assume the REB Chair's responsibilities for the specific project(s).

5.5 REB Office Personnel

5.5.1 All REB Office Personnel are expected to disclose any conflicts that arise and any REB Office Personnel whose job status or compensation is impacted by research that is reviewed by the REB must recuse themselves when such research is reviewed;

5.5.2 Any disclosure of a COI by REB Office Personnel should be referred to the REB Chair or Designee for the development of a management plan;

5.5.3 If REB Office Personnel are unclear as to whether a COI exists, they must contact the REB Chair or Designee to seek clarification. The REB Chair or Designee will determine whether the circumstances should be defined as a COI.

5.6 External Ad Hoc Advisors

5.6.1 At their discretion, the REB Chair or Designee may invite individuals with competence in special areas to assist in the review of issues that require

expertise beyond or in addition to that available on the REB;

5.6.2 All ad hoc advisors must sign a *Confidentiality of Information and Conflict of Interest Agreement* prior to commencement of their consultation and disclose any COI to the REB Chair.

5.6.3 Any disclosure of a COI by an ad hoc advisor should be referred to the REB Chair or Designee for the development of a management plan, as applicable.

5.6.4 If ad hoc advisors are unclear as to whether a COI exists, they must contact the REB Chair or Designee to seek clarification. The REB Chair or Designee will determine whether the circumstances should be defined as a COI.

5.7 Documentation

5.7.1 All REB members, guests, and ad hoc advisors sign a *Confidentiality of Information and Conflict of Interest Agreement* and agree to abide by the REB COI and confidentiality policies;

5.7.2 REB members sign a *Confidentiality of Information and Conflict of Interest Agreement* annually, or as determined by the organization;

5.7.3 The signed *Confidentiality of Information and Conflict of Interest Agreement* is filed in the REB office;

5.7.4 The REB minutes will record any COI that are declared on any of the projects under review at the REB meeting, and the decision on the management of the conflict;

5.7.5 The REB minutes will also record the recusal of an REB member;

5.7.6 At the time of hire, all REB Office Personnel sign a *Confidentiality of Information and Conflict of Interest Agreement* as a condition of their employment with the organization agreeing to abide by the COI and confidentiality policies of the organization. REB Office Personnel must also comply with REB COI SOPs;

5.7.7 The signed *Confidentiality of Information and Conflict of Interest Agreement* will be retained;

5.7.8 The REB management plan for Research COI declarations will be documented in the appropriate research files. Any discussion at the REB meeting regarding the COI and the management plan will be documented in the REB meeting minutes.

6.0 REFERENCES

See References.

7.0 REVISION HISTORY

SOP Code	Effective Date	Summary of Changes
SOP105A.001	15-Sept-2014	Original version
SOP105A.002	08-Mar-2016	No revisions needed
SOP105A.003	08-Oct-2019	No revisions needed
SOP105A.004	15-May-2023	No revisions needed
SOP105A.005	14-Apr-2026	1.0: added ‘real’ and ‘perceived’ to first sentence “...describes real, perceived or potential conflicts of interest...” 2.0: revised ‘guidelines’ to ‘policies’. 5.1.3 and 5.6.1: revised ‘he/she’ and ‘his/her’ to ‘they/their’ 5.2.4: revised ‘should abstain’ to ‘must abstain’. 5.8: previous wording on ‘Institutional Conflicts of Interest’ moved to SOP 105C.

Title	Conflicts of Interest – Researcher
SOP Code	105B.005
Effective Date	14-Apr-2026

Site Approvals

Name and Title (typed or printed)	Signature	Date dd/Mon/yyyy

1.0 PURPOSE

This standard operating procedure (SOP) describes real, potential, or perceived Conflicts of Interest (COI) for Researchers and research staff engaged in human Participant research, and the requirements and procedures for disclosure and managing COI.

2.0 SCOPE

This SOP pertains to Research Ethics Boards (REBs) that review human Participant research in compliance with applicable regulations and policies.

3.0 RESPONSIBILITIES

All REB members, REB Office Personnel, and Researchers are responsible for ensuring that the requirements of this SOP are met.

Researchers are responsible for disclosing any real, potential, or perceived COI to the REB.

The REB is responsible for determining whether the disclosed COI is likely to affect or appear to affect the design, conduct, or reporting of the research.

4.0 DEFINITIONS

See Glossary of Terms.

5.0 PROCEDURE

COI (real, potential, or perceived) arise when an individual in a position of trust has competing professional or personal interests. Such competing interests may influence their professional judgment, objectivity, and independence and can potentially influence the outcome of a decision, for personal benefit. A COI may exist even if no unethical or improper act results from the conflict.

Researchers and research staff should identify and manage COI to maintain the public confidence and trust, and to maintain the independence and integrity of the research process. If a COI cannot be avoided, procedures should be in place to manage and/or mitigate the conflict.

This SOP is not intended to prohibit Researcher relationships with companies; however, the REB should ensure that Participant protection, the integrity of the ethics review, and the conduct of the research are not jeopardized by an unidentified and unmanaged COI.

REBs should identify and manage COI to maintain public confidence and trust, and to maintain the independence and integrity of the ethics review. If a COI cannot be avoided, procedures should be in place to mitigate the conflict.

The REB must be perceived to be fair and impartial, immune from pressure either by the Sponsor, affiliated organizations, Researchers whose research is being reviewed, or by other professional and/or nonprofessional sources.

The standard that guides decisions about determining COI is whether an independent observer could reasonably question whether the individual's actions or decisions are based on factors other than the rights, welfare, and safety of the Participants.

5.1 Researcher Disclosure of Conflicts of Interest

5.1.1 Researchers submitting research applications to the REB are required to declare any COI including those of their sub/co-Researcher(s), research staff, and their immediate families (which includes a spouse, domestic partners, and dependent child), and close relationships;

5.1.2 The Researcher shall disclose any conflicts to the REB at the following times:

- With the initial REB application,

- At each continuing review of the project,
- Whenever a COI arises, such as changes in responsibilities or financial circumstances;

5.1.3 The Researcher is additionally required to provide information on the clinical trial budget, as applicable, when submitting a research application;

5.1.4 Disclosures shall be in writing and sufficiently detailed to allow accurate and objective evaluation of conflict;

5.1.5 The Researcher shall cooperate with the REB and with other officials involved in the review of the pertinent facts and circumstances regarding any COI disclosed, and shall comply with all the requirements of the REB and with their organizational COI policies to eliminate and/or to manage the conflict;

5.1.6 The Researcher shall ensure that all requirements from any COI reviews are appropriately incorporated into the corresponding informed consent documents and research, as applicable.

5.2 REB Review of Researcher Conflict of Interest

5.2.1 The REB will review each application for disclosure of COI;

5.2.2 If the Researcher indicates on the REB application that a conflict exists, the REB will determine whether the disclosed COI is likely to affect or appear to affect the design, conduct, or reporting of the research;

5.2.3 The REB review shall focus on those aspects of the COI that may reasonably affect human Participant protection and the steps taken should be context-based and commensurate with the risks;

5.2.4 In determining the appropriate action, the REB may take into consideration information presented by the Researcher such as:

- The nature of the research,
- The magnitude of the interest or the degree to which the conflict is related to the research,
- The extent to which the interest could affect the research,
- Whether a specific individual is unique in their clinical or scientific qualifications to conduct the research,
- The degree of risk to the human Participants involved in the research that is inherent in the research, and/or
- The management plan for the COI already developed by the Researcher;

5.2.5 The REB may approve the research and may require a management plan, which may include changes at the Researcher's or Sponsor's expense, to eliminate or mitigate the conflict. The researcher may be required to provide a management plan for review by the REB. Required actions may include, but are not limited to:

- Divestiture or termination of relevant economic interests,
- Mandating Researcher recusal from research,
- Modifying or limiting the participation of the Researcher in all or in a portion of the research,
- In cases involving equity, by imposing a bar on insider trading or requiring the transfer of securities to an independent financial manager or blind trust, or limiting the timing of sales or distributions,
- Monitoring research (i.e., independent review of data and other retrospective review for bias, objectivity, comprehensiveness of reporting (versus withholding data)),
- Independent clinical review of appropriateness of clinical care given to research Participants, if applicable,
- Monitoring the consent process, and/or
- Disclosure of the conflict to organizational committees, research Participants, journals, and the data safety monitoring boards;

5.2.6 The REB has the final authority to determine whether a COI has been eliminated or managed appropriately;

5.2.7 Any COI management plan will be documented in the final project files. Any discussions at the REB meeting regarding the COI and the management plan will be documented in the REB meeting minutes;

5.2.8 After review by the REB and input by the appropriate Organizational Official, if applicable, the REB may reject research that involves a COI that cannot be appropriately managed.

6.0 REFERENCES

See References.

7.0 REVISION HISTORY

SOP Code	Effective Date	Summary of Changes
SOP105B.001	15-Sept-2014	Original version
SOP105B.002	08-Mar-2016	No revisions needed
SOP105B.003	08-Oct-2019	5.2.5: inclusion of: 'The researcher may be required to provide a management plan for review by the REB'
SOP105B.004	15-May-2023	Changed his/her to their
SOP105B.005	14-Apr-2026	1.0 added 'real or perceived' 2.0 revised 'guidelines' to 'policies'.

N2 NETWORK OF NETWORKS RÉSEAU DES RÉSEAUX

CAREB ACCER

SOP 105C.005

Title	Conflicts of Interest - Organization
SOP Code	105C.005
Effective Date	14-Apr-2026

Site Approvals

Name and Title (typed or printed)	Signature	Date dd/Mon/yyyy

1.0 PURPOSE

This standard operating procedure (SOP) describes real, potential, or perceived Conflicts of Interest (COI) in the relationship between the organization establishing the Research Ethics Board (REB) and the REB itself, and the requirements and procedures for disclosure and for managing potential COI within this relationship.

2.0 SCOPE

The SOP pertains to REBs that review human Participant research in compliance with applicable regulations and policies.

3.0 RESPONSIBILITIES

All REB members and REB Office Personnel are responsible for ensuring that the requirements of this SOP are met.

4.0 DEFINITIONS

See Glossary of Terms.

5.0 PROCEDURE

Organizational policies should address the roles, responsibilities, and processes for identifying, eliminating, minimizing, or otherwise managing COI relevant to research, including disclosure to REBs. Management of COI includes, but is not limited to, prevention, evaluation, disclosure, and the application of appropriate remedies as defined by the organization.

The REB must be fair and impartial, immune from pressure by the Sponsor, the parent organization, and the Researchers whose research is submitted for review. In the interest of public trust and the integrity of the ethics review, the REB must act independently from its parent organization and avoid or manage real or apparent COI. The organization must respect the autonomy of the REB and ensure that the REB has the appropriate financial and administrative independence to fulfill its primary duties.

The standard that should guide decisions about determining conflicting interests is whether an independent observer could reasonably question whether the REB actions or decisions could be based on factors other than the rights, welfare, and safety of the research Participants.

5.1 Institutional Conflicts of Interest

5.1.1 Where the REB exists within an organization that also funds or sponsors research, the organization must take explicit steps to prevent institutional (COI). These include ensuring that funding departments or individuals do not influence REB deliberations, decisions, or timelines. Any such potential institutional COI shall be disclosed and managed in accordance with TCPS2 (2022) Articles 6.2–6.3.

5.2 Disclosure of Conflict of Interest

5.2.1 All organizational employees must be familiar with the Conflict of Interest Policy and must complete a Disclosure of Conflict of Interest Form(s) (if applicable) at the time of hire and annually thereafter, or as per organizational policy;

5.2.2 Prior to engaging in any of the professional activities listed in the Conflict of Interest Policy, employees must seek the approval of the appropriate Organizational Official to ensure that no conflict exists in doing so;

5.2.3 REB members shall be apprised of the organizational structure with emphasis placed on the independent nature of the relationship between the REB and the organization. The actions of the REB members relating to their responsibilities to protect human research Participants shall not be measured or evaluated in terms of organizational or financial goals;

5.2.4 REB meetings are closed to employees of the organization unless they are REB members, REB Office Personnel, permitted as observers, or invited by the REB to provide information, and only after signed confidentiality agreements are in place;

5.2.5 Organizational senior administrators shall not serve as REB members nor observe REB meetings when their presence may influence REB deliberations.

5.3 Management of Conflicts of Interest

5.3.1 The REB Chair or Designee must be notified if an organizational COI relating to the REB is declared or discovered;

5.3.2 The REB Chair or Designee must be notified immediately if any organizational employee attempts to, or appears to attempt to, influence the research ethics review process or to obtain preferential treatment;

5.3.3 The REB Chair or Designee will review the available information to determine if a conflict exists, and to determine those aspects of the COI that might reasonably affect human Participant protection;

5.3.4 The REB Chair or Designee may require a management plan, which may include actions to eliminate or to mitigate the conflict. Required actions may include, but are not limited to:

- Divestiture or termination of relevant economic interest,
- Recusal of REB Office Personnel whose job status or compensation is impacted by research that is reviewed by the REB,
- If organizational staff members are involved, inform the appropriate responsible organizational management personnel to develop and implement a management plan for remediation;

5.3.5 If the REB Chair or Designee is unable to satisfactorily manage the COI, or if there are unresolved concerns about any undue influence on the REB, the REB Chair or Designee will bring this to the appropriate Organizational Officials for determination of the appropriate course of action;

5.3.6 In the event that the REB Chair or Designee cannot bring the matter to the appropriate Organizational Officials because of an emergent situation or competing COI with the organization, the REB Chair or Designee may escalate the issue to the board authority.

6.0 REFERENCES

See References.

7.0 REVISION HISTORY

SOP Code	Effective Date	Summary of Changes
SOP105C.001	15-Sept-2014	Original version
SOP105C.002	08-Mar-2016	No revisions needed
SOP105C.003	08-Oct-2019	No revisions needed
SOP105C.004	15-May-2023	No revisions needed
SOP105C.005	14-Apr-2026	1.0: added ‘real or perceived’. 2.0: revised ‘guidelines’ to ‘policies’. 5.0: added last paragraph – moved here from 105A.

Title	Signatory Authority
SOP Code	106.005
Effective Date	14-Apr-2026

Site Approvals

Name and Title (typed or printed)	Signature	Date dd/Mon/yyyy

1.0 PURPOSE

This standard operating procedure (SOP) specifies who has the authority to sign documents on behalf of the Research Ethics Board (REB) and describes the responsibilities of authorized individuals, and the conditions under which signing authority may be delegated.

2.0 SCOPE

This SOP pertains to REBs that review human Participant research in compliance with applicable regulations and policies.

3.0 RESPONSIBILITIES

All REB members and REB Office Personnel are responsible for ensuring that the requirements of this SOP are met.

The REB Chair or Designee is responsible for signing documents related to REB review and approval of research. If the task of signing is delegated to a qualified individual or individuals, the responsibility for oversight remains with the REB Chair.

4.0 DEFINITIONS

See Glossary of Terms.

5.0 PROCEDURE

REBs are accountable for their activities and decisions, and appropriate controls must be applied to ensure that documentation related to REB review and approval of research is signed by a person or persons with the appropriate authority to do so.

5.1 Delegation of Signing Authority

5.1.1 The REB Chair or Designee may delegate signing authority for documents related to REB review and approval;

5.1.2 The REB Chair or Designee may only delegate signing authority to REB members or REB Office Personnel with the skill and knowledge necessary for the effective exercise of the authority;

5.1.3 The REB Chair or Designee must not delegate their signing authority to ad hoc advisors or to independent contractors;

5.1.4 The REB Chair or Designee must clearly define the parameters of any delegated authority;

5.1.5 The REB Chair or Designee may delegate signing authority indefinitely or for defined periods of time (e.g., for absences);

5.1.6 The delegation of signing authority must be documented and retained on file.

5.2 REB Reviews, Decisions, and Other Correspondence with the Researcher

5.2.1 For each submission reviewed at a Full Board meeting, the responsible REB Office Personnel records the decision made by the Full Board;

5.2.2 Communication of the REB decision made at a Full Board meeting must be reviewed and authorized by the REB Chair or Designee or as otherwise delegated by the REB Chair or Designee;

5.2.3 For each submission that undergoes Delegated review, the Reviewer's decision is documented;

5.2.4 Once a final decision is documented by the REB Chair or Designee, the responsible REB Office Personnel must issue the decision or letter;

5.2.5 Letters, memos, or emails between the REB and Researchers that provide information about the review of research (e.g., requests for consent form changes, requests for additional information) and that do not imply or appear to imply approval of the research, may be issued as per delegated signing authority;

5.2.6 All activities are documented in the research file including reviews, actions, decisions, signatures, and all correspondence;

5.3 Correspondence with External Agencies

5.3.1 The responsible Organizational Official, REB Chair, or Designee signs all correspondence with agencies of the federal government (Health Canada, OHRP, FDA) and with all funding agencies and/or Sponsors.

6.0 REFERENCES

See References.

7.0 REVISION HISTORY

SOP Code	Effective Date	Summary of Changes
SOP106.001	15-Sept-2014	Original version
SOP106.002	08-Mar-2016	No revisions needed
SOP106.003	08-Oct-2019	No revisions needed
SOP106.004	15-May-2023	No revisions needed
SOP106.005	14-Apr-2026	1.0: revised ‘such individuals’ to ‘authorized individuals’; revised ‘circumstances’ to ‘conditions’. 2.0: revised ‘guidelines’ to ‘policies’. 5.0: revised ‘are’ to ‘is’.5.1.3, 5.2.4: replaced ‘may’ with ‘must’ 5.1.4: replaced ‘should’ with ‘must’ and ‘the’ with ‘any’ 5.1.6: replace ‘kept’ with ‘retained’ 5.2.6: deleted ‘Any’ (previously the first word); replaced ‘concerning’ with ‘about’.

SOP 107.005

Title	Use and Disclosure of Personal Information
SOP Code	107.005
Effective Date	14-Apr-2026

Site Approvals

Name and Title (typed or printed)	Signature	Date dd/Mon/yyyy

1.0 PURPOSE

This standard operating procedure (SOP) describes the responsibilities of the Research Ethics Board (REB) and the REB office in protecting Personal Information (PI), including Personal Health Information (PHI), in accordance with applicable privacy legislation.

2.0 SCOPE

This SOP pertains to REBs reviewing research involving human Participants, particularly where identifiable PI or PHI is collected, used, disclosed, linked, or stored.

3.0 RESPONSIBILITIES

All REB members, REB Office Personnel, and Researchers are responsible for ensuring that the requirements of this SOP are met.

The Researcher is responsible for submitting information to the REB and to the Participant regarding the nature of the PI (including PHI) that will be collected for the research, including the manner in which it is identified, collected, accessed, used, disclosed, retained, disposed of, and protected.

The REB and the REB Office personnel are responsible for ensuring compliance with the applicable policies and procedures regarding the use and disclosure of PI. This includes evaluating privacy risk, reviewing data protection practices, and responding to potential or actual breaches of privacy.

Each organization's privacy office is responsible for providing Researchers and research staff with guidance on privacy policies and regulations.

4.0 DEFINITIONS

See Glossary of Terms.

5.0 PROCEDURE

Privacy is a fundamental value essential for the protection and promotion of human dignity. Breaches of privacy and confidentiality may cause harm to individuals or groups of individuals. Hence, PI must be collected, used, and disclosed in a manner that respects a research Participant's right to privacy, and in accordance with applicable federal and provincial privacy regulations.

Privacy regulations permit the use and limited disclosure of PI for research purposes, provided certain requirements are met. One of the key ethical challenges for the health research community is appropriately protecting the privacy and confidentiality of PI used for research purposes. The REB plays an important role in balancing the need for research with the risk of infringement of privacy, and in minimizing invasions of privacy for research Participants. Individuals must be protected from any harm that may result from the unauthorized use of their PI, and they should expect that their rights to privacy and confidentiality will be respected.

5.1 REB Review of Privacy Concerns

5.1.1 The REB shall review the submitted research to determine whether the Researcher has access to and/or is using PI, and whether appropriate privacy legislation is being followed;

5.1.2 In reviewing the research, the REB will include such privacy considerations as:

- The type of PI to be collected,
- The research objectives and justification for the requested personal data needed to fulfill these objectives,
- The purpose for which the personal data will be used,
- How the personal data will be controlled, accessed, disclosed, and de-identified,
- Limits on the use, disclosure, and retention of the personal data,
- Any anticipated secondary uses of identifiable data from the research,
- Any anticipated linkage of personal data gathered in the research with other data about research Participants, whether those data are contained in public or in personal records,

- Whether consent is required for access to, or the collection of personal data from Participants,
- How consent is managed and documented,
- If and how prospective research Participants will be informed of the research,
- How prospective research Participants will be recruited,
- The administrative, technical, and physical safeguards and practices in place to protect personal data including de-identification strategies and managed linkages to identifiable data,
- How accountability and transparency in the management of personal data will be ensured,
- Whether data will be stored or transferred across provincial or international borders and if so, how jurisdictional privacy laws will be met;

5.1.3 The REB must find that there are adequate provisions to protect the privacy interests of Participants before approving the research.

5.2 Receipt, Use, and Disclosure of PI

5.2.1 The REB Chair, REB members, and REB Office Personnel are bound by confidentiality agreements signed prior to the commencement of their duties;

5.2.2 The REB does not intentionally collect PI;

5.2.3 Subject to consent, as applicable, the REB is permitted to access PI for the purposes of review, approval, ongoing monitoring, and/or the auditing of the conduct of the research;

5.2.4 The REB office must adopt reasonable safeguards and ensure that training is provided for REB Office Personnel to protect PI from unauthorized access;

5.2.5 REB members or REB Office Personnel may consult with the REB Chair or Designee if they are uncertain about the appropriate use or disclosure of PI;

5.2.6 If any PI is received inadvertently in the REB office (e.g., disclosed by a Researcher), appropriate notification must take place and any corrective action that is required including the notification to the appropriate Organizational Official, must be undertaken. The facts surrounding any actual or suspected breach, the appropriate steps taken to manage the breach, remedial activities to address the breach, and the outcome must be documented. The PI must be destroyed in a secure manner in accordance with the organizational policies and procedures;

If there is an internal breach involving the use or dissemination of PI, the REB Chair or Designee will be notified, and if applicable, the appropriate

Organizational Official will also be notified, and a determination will be made in a timely manner regarding a corrective action plan. This process may include notification, containment, investigation, remediation, and strategies for prevention. The facts surrounding the breach or suspected breach must be documented. Documentation shall follow institutional privacy breach protocols and include audit trails, if available. The PI will be destroyed in a secure manner in accordance with the organizational policies and procedures;

5.2.7 At the discretion of the REB Chair or Designee, in consultation with the organization, the provincial privacy office (or equivalent) may be notified.

6.0 REFERENCES

See References.

7.0 REVISION HISTORY

SOP Code	Effective Date	Summary of Changes
SOP107.001	15-Sept-2014	Original version
SOP107.002	08-Mar-2016	No revisions needed
SOP107.003	08-Oct-2019	No revisions needed
SOP107.004	15-May-2023	No revisions needed
SOP107.005	14-Apr-2026	1.0: revised 'duties' to 'responsibilities; added 'including Personal Health Information (PHI), in accordance with applicable privacy legislation.' 2.0: revised from 'This SOP pertains to REBs that review human participant research in compliance with applicable regulations and guidelines; changed 'guidelines' to 'policies'; added reference to PHI. 3.0: added 'The REB and the REB Office personnel are responsible for ensuring compliance with the applicable policies and procedures regarding the use and disclosure of PI. This includes evaluating privacy risk, reviewing data protection practices, and responding to potential or actual breaches of privacy.' 5.0: minor wording changes, e.g. 'provided' in place of 'as long as; 'must' in place of 'should'; 'with' in place of 'against'; 'will be' in place of 'are'. 5.1.2: added 'Whether data will be stored or' transferred across provincial or international borders and if so, how jurisdictional privacy laws will be met'; 5.2.6: added '...any actual or suspected breach...'; revised 'as per' to 'in accordance with'.

		5.2.7; revised 'notification of the appropriate Organizational Official' to "the appropriate Organizational Official will also be notified.'; 3rd sentence, added 'and appropriate steps taken to manage the breach and the outcome will be documented. Documentation shall follow institutional privacy breach protocols and include audit trails, if available.'; revised 'as per' to 'in accordance with'.

SOP 108.005

Title	Standard Operating Procedures Maintenance by Network of Networks and CAREB
SOP Code	108.005
Effective Date	14-Apr-2026

Site Approvals

Name and Title (typed or printed)	Signature	Date dd/Mon/yyyy

1.0 PURPOSE

This standard operating procedure (SOP) describes the processes for establishing and maintaining written SOPs. The purpose of written SOPs is to promote quality and consistency in the ethics review process; ensure compliance with principles, policies, and regulations governing the ethics review and oversight of research involving humans; and support the training of new personnel. The Research Ethics Board (REB) SOPs are prepared and distributed by N2.

2.0 SCOPE

The REB SOPs are made available to REBs that review human Participant research in accordance with applicable regulations and policies.

3.0 RESPONSIBILITIES

The N2/CAREB REB SOP Committee is responsible for developing and maintaining this set of SOPs to ensure compliance with the requirements outlined in this SOP are met.

4.0 DEFINITIONS

See Glossary of Terms.

5.0 PROCEDURE

Written SOPs provide the framework to promote ethical standards in the review, oversight, and conduct of research involving human Participants. SOPs outline the processes that must be followed and documented to ensure that the rights and welfare of human Participants are overseen and protected in a uniform manner.

5.1 Development, Review, Revision, and Approval of Policies & Procedures

5.1.1 The REB SOP Committee will review the SOPs at least every 3 years. If revisions are not required a memo will be posted alongside the documents to indicate that the review was conducted. Applicable SOPs will be reviewed sooner if changes to regulations, policies, or standard practice warrant revisions or the creation of new SOPs;

5.1.2 SOPs may be revised for reasons including, but not limited to: changes to regulations or guidelines, new or revised policies, or changes to REB or administrative practices;

5.1.3 The REB SOP Committee will make the necessary modifications to existing SOPs or draft new SOPs. SOPs are controlled documents, and new drafts will be indicated by the addition of “DRAFT version date” and removal of the previous “Final Version Date”;

5.1.4 The revised SOP(s) will be circulated to the REB SOP Committee for review. Comments will be incorporated into a new version with an updated version date;

5.1.5 Once the SOP content is approved, the draft version date will be removed, and the date of the approved version will be entered as the “Final Version Date”. The history of revisions will be recorded in the ‘Revision History’ section of each SOP;

5.1.6 Signatures on the SOP, as determined by organizational policy, will denote SOP approval. A new final version of the SOP supersedes any previous versions.

5.2 Distribution and Communication

5.2.1 New or revised SOPs will be communicated and disseminated through posting on the N2 and CAREB websites.;

5.2.2 The SOPs will be available to REBs, Researchers, researcher sites, Sponsors, and Regulatory Authorities as required;

5.2.3 Qualified REB Office Personnel will train members of the REB and the REB Office Personnel on any new or revised policies and/or any relevant procedures, as applicable;

5.2.4 Each new REB member must review the applicable policies and procedures prior to undertaking their responsibilities as an REB member;

5.2.5 Each new REB Office Personnel must review the applicable policies and procedures prior to undertaking their responsibilities in the REB office;

5.2.6 Evidence of training must be documented and retained in accordance with institutional record retention policies.

5.2.7 The REB office shall maintain all documentation of SOP training.

5.3 Forms, Memos and Guidance Documents

5.3.1 Forms such as checklists and worksheets may be developed to facilitate compliance with the SOPs and to ensure that policies are integrated into daily operations. Forms may be either controlled or non-controlled;

5.3.2 Memos and guidance documents may be developed to provide guidance for the interpretation and implementation of the SOP;

5.3.3 Memos and guidance documents will be made available to Researchers and researcher sites as applicable;

5.3.4 The REB SOP Committee will evaluate the need for new or revised forms, memos, or guidance documents.

6.0 REFERENCES

See References.

7.0 REVISION HISTORY

SOP Code	Effective Date	Summary of Changes
SOP108.001	15-Sept-2014	Original version
SOP108.002	08-Mar-2016	No revisions needed
SOP108.003	08-Oct-2019	5.1.1: revision (sp) of word biennial
SOP 108.004	15-May-2023	Responsibility for the SOP revised to indicate the responsibility for the management of the SOPs is with the N2/CAREB REB SOP Committee
SOP 108.005	14-Apr-2026	1.0, 2.0 and 5.1.1, replaced “guidelines” with “policies”. 1.0 replaced “outlines” with “describes”; deleted “applicable to” from “regulations applicable to governing...”; replaced ‘facilitate’ with ‘support’.

		2.0: replaced “compliance” with “accordance”. 3.0: minor wording revisions to match wording in 1.0 and 2.0. 5.0: replaced ‘describe’ with ‘outlines’; deleted ‘of such research’ from the last sentence. 5.1.1: replaced ‘reversioning’ with ‘revisions’. 5.1.2: added ‘...or revised’ to ‘...new or revised...’. 5.2: minor wording changes e.g. pluralization. 5.2.4: replaced ‘his/her’ with ‘their’. 5.2.6: added ‘...and retained in accordance with institutional record retention policies.’

Title	Composition of the REB
SOP Code	201.005
Effective Date	14-Apr-2026

Site Approvals

Name and Title (typed or printed)	Signature	Date dd/Mon/yyyy

1.0 PURPOSE

This standard operating procedure (SOP) describes the membership composition requirements of the Research Ethics Board (REB).

2.0 SCOPE

This SOP pertains to REBs that review human Participant research in compliance with applicable regulations and policies.

3.0 RESPONSIBILITIES

All REB members and REB Office Personnel are responsible for ensuring that the requirements of this SOP are met.

The REB Chair or Designee is responsible for ensuring that the composition of the REB meets the applicable regulatory requirements.

4.0 DEFINITIONS

See Glossary of Terms.

5.0 PROCEDURE

Individual members of an REB must be qualified through training, experience, and expertise to ascertain the acceptability of proposed research in terms of ethical principles, and applicable regulations, policies, and standards pertaining to human Participant protection.

To promote complete and adequate review of the type of research commonly reviewed by the REB, the REB must include appropriate diversity; therefore, selection of members must include a consideration of professional expertise (including both scientific and non-scientific) to assess the research submitted for review. Important considerations also include race, sex, cultural backgrounds, clinical and research experience, organizational affiliation, and sensitivity to such issues as broad representation from organizations served by the REB.

5.1 Selection of REB Members

5.1.1 In the selection of REB members, equal consideration shall be given to qualified persons of both sexes. No appointment shall be made solely on the basis of sex;

5.1.2 The REB will make every effort to include cultural and ethnic minorities to represent the population from which research Participants are recruited, within the scope of available expertise needed to conduct its functions;

5.1.3 The REB membership will not consist entirely of members of one profession;

5.1.4 REB members will be selected based on the needs of the REB as outlined below and per applicable regulations, policies, and standards.

5.2 Composition of the REB

5.2.1 The membership of the REB will be in compliance with the *Food and Drugs Act* and applicable *Regulations*, the Tri-Council Policy Statement (TCPS2); Ethical Conduct for Research Involving Humans, the International Council for Harmonisation Good Clinical Practice (ICH E6(R3)) Guidelines (2025), which emphasize a proportionate, risk-based approach to trial conduct and oversight, and the US Code of Federal Regulations. For research funded or regulated by U.S. agencies, Canadian REBs may be required to comply with applicable U.S. federal regulations, such as the Common Rule (45 CFR 46) and FDA regulations (21 CFR Parts 50 and 56), to the extent they do not conflict with Canadian law

and policy.

5.2.2 The REB Chair or Designee monitors the REB membership composition for appropriate membership in relation to the nature and volume of research submissions;

5.2.3 The REB will include at least five members represented by the following categories:

- At least two members who have expertise in relevant research disciplines, field, and methodologies covered by the REB (for biomedical clinical trials, this will include at least one member who practises medicine or dentistry and who is in good standing with their regulatory body),
- At least one member who is primarily experienced in non-scientific disciplines,
- At least one member who is knowledgeable in ethics,
- At least one member who is knowledgeable in the relevant law. This is mandatory for biomedical research and is advisable, but not mandatory, for other areas of research, and
- At least one community member who has no affiliation with the organization or the Sponsor, and who is not part of the immediate family of a person who is affiliated with the organization;

5.2.4 A member may not fulfill more than two representative capacities or disciplines;

5.2.5 Members will include men and women, a majority of whom are Canadian citizens or permanent residents, and who collectively have the qualifications and experience to review and evaluate the science, medical aspects, and ethics of the proposed research;

5.2.6 Membership, when required, should include at least one member who has expertise in complementary or alternative care or pediatric health research;

5.2.7 Membership, when regularly required, for the review of research on topics related to Indigenous peoples or affecting Indigenous communities, should include a member with relevant and competent knowledge and expertise in Indigenous cultures, or the inclusion of an ad hoc advisor for occasional review.

5.2.8 Additional membership as required by applicable legislation or policies.

5.3 Alternate Members

5.3.1 The REB Chair or Designee may ask an alternate REB member to attend an REB meeting to draw on their expertise in an area that may be relevant to that

meeting's deliberations, or to establish a quorum for that meeting in the absence of the regular REB member;

5.3.2 Only alternate REB members of comparable qualifications may substitute for an REB member (a non-scientific member may not substitute for a scientific member);

5.3.3 The minutes shall document when an alternate REB member replaces a primary REB member.

5.4 REB Chair

5.4.1 Whenever possible and practicable, the REB Chair will be selected from experienced REB members who have expressed interest in becoming the REB Chair and who are familiar with the applicable regulations and policies;

5.4.2 The REB Office Personnel updates the REB membership roster and the US Office for Human Research Protection (OHRP) registration, if applicable, to reflect this change.

5.5 Ad Hoc Advisors

5.5.1 At their discretion, the REB Chair or Designee may invite individuals with expertise and competence in special areas to assist in the review of issues that require expertise beyond or in addition to that available on the REB;

5.5.2 The ad hoc advisor may be asked to participate in the REB meeting to lend their expertise to the discussions;

5.5.3 All ad hoc advisors shall sign a *Confidentiality of Information and Conflict of Interest Agreement;*

5.5.4 The ad hoc advisor may not contribute directly to the REB's decision, and their presence or absence shall not be used in establishing a quorum;

5.5.5 Documentation of key information provided by the ad hoc advisor shall be summarized in the REB minutes and if available, the written report shall be placed in the REB files.

5.6 Observers at REB Meetings

5.6.1 The REB may allow observers to attend its meetings;

5.6.2 Observers will sign a *Confidentiality of Information and Conflict of Interest Agreement* agreeing to abide by the REB conflict of interest and confidentiality

policies;

5.6.3 Where the REB finds that an observer qualifies as an expert in relation to the research under consideration, the observer may be allowed to contribute input if it is relevant and significant to the discussion; in that case, they may be deemed an ad hoc advisor and section 5.5 applies.

5.6.4 Observers shall not participate when the REB discusses its decision, reaches consensus, or votes on the application;

5.6.5 The minutes will reflect the presence of any observers as well as their expertise and contributions, when applicable.

6.0 REFERENCES

See References.

7.0 REVISION HISTORY

SOP Code	Effective Date	Summary of Changes
SOP201.001	15-Sept-2014	Original version
SOP201.002	08-Mar-2016	No revisions needed
SOP201.003	08-Oct-2019	5.2.1: ICH 'Conference' changed to 'Council'; Removed "Research ethics oversight of biomedical clinical trials (CAN/CGSB-191.1-2013) 5.2.7: change in language and requirements for addressing research involving the Indigenous community. Removal of: 'At least one member, when possible, who is from an identifiable Aboriginal community or Native centre, when the REB reviews research that recruits participants from that community'; New Language: 'Membership, when regularly required, for the review of research on topics related to Indigenous peoples or affecting Indigenous communities, should include a member with relevant and competent knowledge and expertise in Indigenous cultures, or the inclusion of an ad hoc advisor for occasional review.'
SOP201.004	15-May-2023	No revisions needed.
SOP201.005	14-Apr-2026	2.0, 5.0, 5.1.4, 5.2.8, and 5.4.1 replaced "guidelines" with "policies". 5.2.1: added E6(R3) language 'which emphasize a proportionate, risk-based approach to trial conduct and oversight'; added 'For research funded or regulated by U.S. agencies, Canadian REBs may be required to comply with

		applicable U.S. federal regulations, such as the Common Rule (45 CFR 46) and FDA regulations (21 CFR Parts 50 and 56), to the extent they do not conflict with Canadian law and policy.

Title	Management of REB Membership
SOP Code	202.005
Effective Date	14-Apr-2026

Site Approvals

Name and Title (typed or printed)	Signature	Date dd/Mon/yyyy

1.0 PURPOSE

This standard operating procedure (SOP) describes the management of the membership of the Research Ethics Board (REB).

2.0 SCOPE

This SOP pertains to REBs that review human Participant research in compliance with applicable regulations and policies.

3.0 RESPONSIBILITIES

All REB members and REB Office Personnel are responsible for ensuring that the requirements of this SOP are met.

The REB Chair or Designee is responsible for monitoring and managing the REB membership.

4.0 DEFINITIONS

See Glossary of Terms.

5.0 PROCEDURE

REB membership (e.g., appointment, terms) must be adequately managed to continue to meet applicable regulatory composition requirements and to maintain the appropriate diversity, experience. and expertise for the type and volume of research reviewed.

5.1 Appointments – Regular Members and Alternates

5.1.1 REB members are appointed as per the organization's REB terms of reference;

5.1.2 Community members (meeting membership requirements) are solicited from the greater local community;

5.1.3 Each REB member selected is approved by the REB Chair or Designee, or as determined by the organizational REB terms of reference;

5.1.4 Candidates selected to serve on the REB will be asked to sign a letter of appointment and a *Confidentiality of Information and Conflict of Interest Agreement*.

5.2 Appointments – REB Chair and Vice-Chair

5.2.1 The REB Chair and Vice Chair (if applicable) are appointed as per the organization's REB terms of reference;

5.2.2 The REB Chair and Vice-Chair will be asked to sign a *Confidentiality of Information and Conflict of Interest Agreement.*

5.3 Ad hoc Advisors

5.3.1 At their discretion, the REB Chair or Designee may invite individuals with competence in special areas to assist in the review of issues that require expertise beyond or in addition to that available on the REB.

5.4 Terms of Appointment

5.4.1 Each REB member will serve for a term specified by the organization;

5.4.2 Re-appointment of an REB member for (an) additional term(s) is allowed, by mutual agreement of the REB member and the REB Chair or Designee;

5.4.3 The REB Chair and Vice-Chair will serve for a term specified by the organization;

5.4.4 Terms will be overlapping to preserve the experience level, expertise, and continuity of the REB.

5.5 Qualifications and Training of REB Members

5.5.1 Each member of the REB will meet qualification criteria and follow training procedures.

5.6 Resignations and Removals

5.6.1 An REB member may resign before the conclusion of their term upon provision of notice to the REB Chair or Designee;

5.6.2 An REB member may be asked to step down if they consistently miss a specified percentage of the scheduled Full Board meetings in their term;

5.6.3 The REB Chair or Designee may otherwise remove an REB member at any time, if they are not fulfilling their designated REB duties in a timely, competent, and ethical manner;

5.6.4 An REB member should resign immediately upon determination of research misconduct, mismanaged conflict of interest, or any other relevant behavior that could be perceived as compromising their ethical judgment;

5.6.5 Every effort will be made to recruit a similarly qualified replacement prior to the departure of a member to preserve the level of experience and expertise, and to ensure the continuity of the functions of the REB.

5.7 Compensation

5.7.1 Compensation and reimbursement of expenses for REB members will be according to organizational policies.

5.8 Liability and Coverage

5.8.1 All REB members are insured for their research ethics review-related work by the organization's insurance policy, subject to the terms and conditions of that policy.

5.9 Documentation

5.9.1 The REB Office Personnel will maintain an updated electronic REB membership list;

5.9.2 The REB membership list is reviewed and updated as required, or with the initiation of any new or conclusion/termination of existing terms;

5.9.3 The current REB membership list and archived lists are maintained and available through the REB office;

5.9.4 CVs, other supporting documents related to education and expertise, signed members' letters of appointment, and confidentiality agreements for all current and past REB members will be maintained in the REB office;

5.9.5 The REB Chair or Designee will maintain the REB membership roster which includes: name, degree(s), area(s) of expertise and organizational affiliation(s), role on the REB (e.g. scientific, nonscientific), sex, Canadian citizenship status, and indications of experience such as board certification, licenses, etc. sufficient to describe each member's chief anticipated contribution to REB deliberations (as applicable);

5.9.6 A detailed membership list will be kept in the REB office. This list will contain REB member contact information and additional information on areas of expertise for the purposes of communication and reviewer assignment. It will be kept confidential for access only by REB members and the REB Office Personnel;

5.9.7 The REB Chair or Designee will update the REB registration with the US Office for Human Research Protection (OHRP) when applicable.

6.0 REFERENCES

See References.

7.0 REVISION HISTORY

SOP Code	Effective Date	Summary of Changes
SOP202.001	15-Sept-2014	Original version
SOP202.002	08-Mar-2016	No revisions needed
SOP202.003	08-Oct-2019	No revisions needed
SOP202.004	15-May-2023	5.3.1 and 5.6.4: revised "his/her" to "their".
SOP202.005	14-Apr-2026	2.0: revised "guidelines" to "policies". 5.2.1 and 5.2.2 which are very similar, were combined into one. 5.5.1: reworded for clarity, "Each member of the REB will *meet* qualification *criteria* and *follow* training procedures".

Title	Duties of REB Members
SOP Code	203.005
Effective Date	14-Apr-2026

Site Approvals

Name and Title (typed or printed)	Signature	Date dd/Mon/yyyy

1.0 PURPOSE

This standard operating procedure (SOP) describes the duties of the members of the Research Ethics Board (REB).

2.0 SCOPE

This SOP pertains to REBs that review human Participant research in compliance with applicable regulations and policies.

3.0 RESPONSIBILITIES

All REB members and REB Office Personnel are responsible for ensuring that the requirements of this SOP are met.

The REB Chair or Designee is responsible for clearly articulating all required duties associated with membership to the REB to potential and current REB members.

REB members and alternates are responsible for fulfilling their duties as specified in this SOP.

4.0 DEFINITIONS

See Glossary of Terms.

5.0 PROCEDURE

Each REB member's primary duty is the protection of the rights and welfare of the individual human beings who are serving as the Participants of research. In order to fulfill their duties, REB members must be versed in regulations governing human Participants' protection and biomedical research ethics, and policies germane to human research Participant protection.

5.1 Attendance

5.1.1 Regular REB members are expected to attend the regularly scheduled REB meetings. REB Members may be asked to step down if they consistently miss a specified percentage of the scheduled REB meetings;

5.1.2 REB members must notify the REB office if they will be absent for an REB meeting to ensure that quorum can still be met and/or so that an appropriate alternate may attend in their place;

5.1.3 Alternate REB members are expected to attend the identified REB meetings for which they have confirmed their availability to replace a regular REB member, and/or a minimum of two REB meetings per year;

5.1.4 REB members are expected to be available for the entire REB meeting, not just the sections for which they have been assigned as Reviewers.

5.2 Terms of Duty

5.2.1 All members of the REB, including the REB Chair and Vice-Chair, will be appointed for a term as specified by organizational policy.

5.3 Duties

5.3.1 All REB members attending an REB meeting are expected to review the relevant materials submitted for each item under review or consideration by the REB, to submit comments in advance of the REB meeting, and to be prepared to discuss each agenda item and provide input at the Full Board meeting;

5.3.2 Each REB member is expected to fulfill specific duties based on the role as outlined below. More than one REB member may fulfill each role;

5.3.3 **Scientific members:** are expected to contribute to the evaluation of the research on its ethical, scientific, and statistical merits and standards of practice. These members should also advise the REB if additional expertise in a scientific or non-scientific area is required to assess whether the research adequately protects the rights and welfare of human Participants;

5.3.4 **Non-scientific members:** are expected to provide input on areas germane to their knowledge, expertise and experience, professional, and otherwise. Non-scientific members should advise the REB if additional experience in a non-scientific area is required to assess whether the research adequately protects the rights and welfare of Participants and to comment on the comprehension of the consent document;

5.3.5 **Community member(s):** are expected to provide input regarding their knowledge about the local community and be able to discuss issues and research from that perspective;

5.3.6 **Member(s) knowledgeable in relevant law:** are expected to alert the REB to legal issues and their implications, but not to provide formal legal opinions nor to serve as legal counsel to the REB;

5.3.7 **Member(s) knowledgeable in ethics:** are expected to guide the REB in identifying and addressing ethics issues related to the research under review;

5.3.8 **Ad hoc advisors:** individuals with competence in special areas may be required to provide input on issues that require expertise beyond or in addition to that available on the REB. The ad hoc advisor may be required to submit a written report and to participate via teleconference, videoconference, or to attend the REB meeting to lend their expertise to the discussions;

5.3.9 **REB Chair:** The REB Chair or Designee provides overall leadership to the REB including:

- Delegating any of their responsibilities, as appropriate, to a Vice-Chair or other qualified individual(s),
- Documenting any responsibilities that are delegated
- Facilitating the review process based on organizational policies and procedures, SOPs and applicable regulations and guidelines.
- Determining the level of risk of each research project,
- Monitoring the REB's decisions for consistency and ensuring that decisions are recorded accurately and communicated to Researchers in writing in a timely fashion,

- Ensuring that all REB members are free to participate in discussions during the REB meetings. The REB Chair or Designee can ask a substitute REB member to attend an REB meeting in order to draw their expertise in an area that may be relevant to the REB's review and deliberations of the research,
- Determining the appropriateness of a Full Board or Delegated review of the research,
- Performing or delegating authority to (an) REB member(s) to conduct a Delegated review,
- Signing off on all REB decisions in writing,
- For REB approval of clinical trials approved by Health Canada, the REB approval letter which includes the REB attestation, is signed by the REB Chair or Designee,
- Suspending the conduct of any research project deemed to place Participants at unacceptable risk pending discussion by the Full Board. The REB Chair or Designee can suspend the conduct of the research if they determine that a Researcher is not adhering to the REB approved protocol or to the REB's policies and procedures,
- Reporting on the activities of the REB to the organization on an annual basis,
- The REB Chair or Designee, in conjunction with the REB Office Personnel and other organizational representatives as applicable, ensures the REB members are informed of all new legislation, regulations, policies and guidelines pertaining to human Participant research and shall advise the organization on policies and procedures related to research conduct,
- The REB Chair, in conjunction with the REB Office Personnel, shall assess the educational and training needs of the REB members and Office Personnel, and will address any gaps identified.
- Reviewing and approving REB policies and procedures at set intervals, to ensure the REB SOPs meet all current standards.

5.3.10 **REB Vice-Chair:** The REB Vice-Chair or equivalent is responsible for performing the responsibilities of the REB Chair when the REB Chair is unable to do so, including:

- Performing all responsibilities assigned by the REB Chair,
- Assisting with the overall operation of the REB.

5.4 Primary and Secondary Reviewers

5.4.1 REB members will act as primary and/or secondary Reviewers for assigned research projects at Full Board meetings. The primary and secondary Reviewers present their findings resulting from review of the REB submission materials,

provide an assessment of the soundness and safety of the research, and recommend specific action to the REB. They lead the discussion of the research project during the REB meeting. The primary and secondary Reviewers review additional material(s) as requested by the REB for the purpose of approval of the research.

5.5 Training and Education

5.5.1 REB members are expected to follow training and education procedures.

5.6 Conflict of Interest

5.6.1 REB members are expected to follow conflict of interest procedures.

6.0 REFERENCES

See References.

7.0 REVISION HISTORY

SOP Code	Effective Date	Summary of Changes
SOP203.001	15-Sept-2014	Original version
SOP203.002	08-Mar-2016	No revisions needed
SOP203.003	08-Oct-2019	No revisions needed
SOP203.004	15-May-2023	Changed his/her to their
SOP203.005	14-Apr-2026	2.0: revised “guidelines” to “policies”. 5.1.4 and 5.4.1: capitalized Reviewer as this term is now defined in the Glossary. 5.3.8: added ‘videoconference’. 5.3.9: revised he/she to they

Title	REB Office Personnel Serving as REB Members
SOP Code	204.005
Effective Date	14-Apr-2026

Site Approvals

Name and Title (typed or printed)	Signature	Date dd/Mon/yyyy

1.0 PURPOSE

This standard operating procedure (SOP) describes the duties of REB Office Personnel serving as members of the Research Ethics Board (REB).

2.0 SCOPE

This SOP pertains to REBs that review human Participant research in compliance with applicable regulations and policies.

3.0 RESPONSIBILITIES

All REB members and REB Office Personnel are responsible for ensuring that the requirements of this SOP are met.

The REB Chair or Designee is responsible for clearly articulating all required duties associated with membership to the REB, including to potential and current REB members.

REB members and alternates are responsible for fulfilling their duties as specified in this SOP.

4.0 DEFINITIONS

See Glossary of Terms.

5.0 PROCEDURE

Each REB member's primary duty is the protection of the rights and welfare of the individual human beings who are serving as the Participants of research. In order to fulfill their duties, REB members must be versed in regulations governing human Participants' protection and biomedical research ethics, and policies germane to human research Participant protection.

5.1 Duties

5.1.1 REB Office Personnel who are designated as Board members may attend convened meetings and participate in discussions, but they shall not be counted in determining a quorum and shall not participate in any votes;

5.1.2 REB Office Personnel that have been appointed to serve as REB members may perform Delegated reviews in accordance with the Delegated review procedure;

5.1.2 The assignment of these tasks to REB Office Personnel will be documented.

5.2 Appointment Criteria

5.2.1 REB Office Personnel serving as REB members shall have knowledge, experience, and training comparable to what is expected of REB members. The REB shall ensure that REB Office Personnel can fulfill their responsibilities as REB members independently.

5.4 Training and Education

5.4.1 REB Office Personnel serving as REB members are expected to additionally follow training and education procedures for REB members.

5.5 Conflict of Interest

5.5.1 REB Office Personnel serving as REB members are additionally expected to follow conflict of interest procedures for REB members.

6.0 REFERENCES

See References.

7.0 REVISION HISTORY

SOP Code	Effective Date	Summary of Changes
SOP204.001	15-Sept-2014	Original version
SOP204.002	08-Mar-2016	No revisions needed
SOP204.003	08-Oct-2019	No revisions needed
SOP204.004	15-May-2023	Replaced “his/her” with “their”.
SOP204.005	14-Apr-2026	2.0: replaced “guidelines” with “policies”.

Title	REB Submission Requirements and Administrative Review
SOP Code	301.005
Effective Date	14-Apr-2026

Site Approvals

Name and Title (typed or printed)	Signature	Date dd/Mon/yyyy

1.0 PURPOSE

This standard operating procedure (SOP) describes the Research Ethics Board (REB) submission requirements and the administrative review procedures. This SOP applies to all submissions including but not limited to, applications for initial review, amendments, and the submission of any new information.

2.0 SCOPE

This SOP pertains to REBs that review human Participant research in compliance with applicable regulations and policies.

3.0 RESPONSIBILITIES

All REB members and REB Office Personnel are responsible for ensuring that the requirements of this SOP are met.

4.0 DEFINITIONS

See Glossary of Terms.

5.0 PROCEDURE

REB members must rely on the documentation provided by the Researcher for initial and continuing review. Therefore, the materials submitted must provide sufficient information to conduct the review and to make the required determinations.

The REB is supported by administrative procedures that ensure that REB members not only have adequate time for the assessment of the proposed research, but that the materials they receive allow them to adequately assess whether the research submission meets the criteria for REB approval.

The requirements for REB submissions are made available to all Researchers. The REB Office Personnel are responsible for maintaining and disseminating this information to Researchers.

5.1 Submission Requirements

5.1.1 The required documents, checklists, number of copies, format, and submission procedures are outlined on the REB's website and on the appropriate REB submission forms and checklists such as, but not limited to:

- REB application form,
- Submission checklist,
- Continuing Review form,
- Amendment and/or Administrative Change form,
- Change in Researcher/Coordinator form,
- Changes in Research Personnel form,
- Serious Adverse Event Reporting form,
- Research Completion form;

5.1.2 The REB may request any additional documentation it deems necessary to the ethics review, or for research ethics oversight;

5.1.3 **Research Requirements:** The research question and methodology are written in sufficient detail to permit the evaluation of the merit of the project. The research should include all of the required elements applicable to the research such as, but not limited to:

- Research rationale and objectives,
- Design and detailed description of methodology,
- Eligibility criteria, and description of the population to be studied,
- Recruitment and consent process,
- Research interventions,

- Treatment allocation (if applicable),
- Primary and secondary outcome measures,
- Assessment of safety,
- Sample size justification,
- Data analysis,
- Data monitoring.
- Literature review

5.2 Administrative Review Procedures

5.2.1 A unique number is assigned to each submission of. REB Office Personnel screens the submission for overall completeness;

5.2.2 If the submission is incomplete (e.g. documents are missing or incorrect documents were uploaded), the REB Office Personnel will follow up with the Researcher and/or Research Coordinator to request the required information for inclusion with the submission;

5.2.3 Upon receipt of a complete submission, the responsible REB Office Personnel identifies any outstanding items that will be required to issue approval, as applicable;

5.2.4 For submissions requiring Full Board review, the REB Office Personnel posts the submission to the agenda of the next Full Board meeting and assign primary and secondary Reviewers, as applicable;

5.2.5 For submissions reviewed via Delegated review procedures, the REB Chair or Designee assigns a Reviewer(s).

6.0 REFERENCES

See References.

7.0 REVISION HISTORY

SOP Code	Effective Date	Summary of Changes
SOP301.001	15-Sept-2014	Original version
SOP301.002	08-Mar-2016	No revisions needed
SOP301.003	08-Oct-2019	No revisions needed
SOP301.004	15-May-2023	No revisions needed
SOP301.005	14-Apr-2026	1.0: reworded for clarity and to align with TCPS2 (2022) and E6(R3) language regarding submission processes and investigator responsibilities. 2.0: changed “guidelines” to “policies”. 5.1.3: added Literature Review. 5.2.1: deleted ‘at the time of receipt of the application’. 5.2.4: deleted “assigned once the agenda is complete, if applicable”. 5.2.4 and 5.2.5: capitalized Reviewer as it is now defined in the Glossary. 5.2.5: deleted sentence fragment ‘and sends the research’.

Title	REB Meeting Administration
SOP Code	302.005
Effective Date	14-Apr-2026

Site Approvals

Name and Title (typed or printed)	Signature	Date dd/Mon/yyyy

1.0 PURPOSE

This standard operating procedure (SOP) describes the required activities for the preparation, management, and documentation of Full Board meetings of the Research Ethics Board (REB).

2.0 SCOPE

This SOP pertains to REBs that review human Participant research in compliance with applicable regulations and policies.

3.0 RESPONSIBILITIES

All REB members and REB Office Personnel are responsible for ensuring that the requirements of this SOP are met.

4.0 DEFINITIONS

See Glossary of Terms.

5.0 PROCEDURE

Except when a Delegated review procedure is used, the REB must review any proposed research at Full Board meetings at which a quorum is present.

The REB meeting agenda provides the meeting content and establishes a sequence of

review. It also provides an overview of all items that have been previously (i.e., during the preceding time between REB meetings) reviewed and approved by Delegated review procedures, a list of items that are pending review by the Full Board, and the assigned Reviewer(s) for each of those items. Information documented in the REB meeting agenda provides the foundation for the REB meeting minutes.

The REB meeting minutes document the actions that occur during an REB meeting. The minutes should enable a reader who was not present at the REB meeting to determine how and with what justification the REB arrived at its decisions. They should also provide the REB with sufficient detail to help it reconstruct its discussions at a later date, if necessary.

5.1 Agenda Preparation

5.1.1 Following an administrative review of the submission (e.g., new studies, amendments, continuing review applications, reportable events) by the REB Office Personnel and the determination of the review type by the REB Chair or Designee, the responsible REB Office Personnel adds any submissions requiring Full Board review to the next appropriate Full Board meeting agenda;

5.1.2 For submissions that were reviewed and approved via Delegated review procedures, the REB will be made aware of these approvals in a timely manner;

5.1.3 The REB Office Personnel attaches to the agenda any previous REB meeting minutes for Full Board review and approval, and adds any other items for information or discussion at the REB meeting (e.g., SOPs, educational articles, presentations, reports, etc.);

5.1.4 The REB Office Personnel, in consultation with the REB Chair or Designee as necessary, reviews the agenda, confirms REB meeting attendance, and assigns the Reviewers;

5.1.5 The REB Chair or Designee invites the appropriate alternate REB member to the meeting when a regular REB member is not able to attend;

5.1.6 The Reviewer assignment and the agenda are issued in a timely manner prior to the REB meeting date. The REB members attending the REB meeting will receive a copy of the REB meeting agenda;

5.1.7 Ad hoc advisors will receive copies of relevant submissions;

5.1.8 Any changes to the agenda are communicated to all REB members and REB Office Personnel. The REB Office Personnel or Designee also may issue an updated agenda notice depending on the nature of the changes.

5.2 Primary and Secondary Reviewers

5.2.1 Prior to the meeting, the REB Office Personnel, in consultation with the REB Chair or Designee as necessary, will assign a primary and may assign one or more secondary Reviewers for each new research project and at least one Reviewer for each amendment;

5.2.2 No REB member will be assigned as a Reviewer on a submission in which they are a Researcher or co-Researcher or in which there is a declared conflict of interest;

5.2.3 The REB Office Personnel will issue the Reviewer assignments. ;

5.2.4 If any of the assigned Reviewers declare a conflict, the submission is reassigned to another Reviewer.

5.3 Prior to the REB Meeting

5.3.1 The primary and secondary Reviewers (if applicable) will conduct in-depth reviews of their assigned submissions and may submit Reviewer comments prior to the REB meeting. The primary Reviewer should be prepared to lead the discussion at the Full Board meeting;

5.3.2 All REB members are expected to conduct a review of each agenda item prior to the Full Board meeting, including previous REB meeting minutes on the agenda and any attachments to the agenda for review or discussion;

5.3.3 REB members who are not assigned as primary or secondary Reviewers may submit their individual comments for each submission prior to the meeting;

5.3.4 All REB members should be prepared to present their comments and participate in the discussion at the Full Board meeting.

5.4 During the REB Meeting

5.4.1 A quorum must be present to proceed with a Full Board meeting;

5.4.2 Should quorum fail during a Full Board meeting (e.g., through recusal of REB members with conflicts of interest or early departures), the REB may not make further decisions unless quorum can be restored;

5.4.3 An alternate REB member may attend in the place of a regular REB member to meet quorum requirements. When a REB member and their alternate both attend the REB meeting, only one is allowed to participate in the deliberations and final decisions regarding approval;

5.4.4 REB meetings may take place in person, via teleconference or videoconference, or using a hybrid of in-person and teleconference or videoconference. Everyone must have access to the review materials and quorum must be met

5.4.5 Ad hoc advisors will not be used to establish a quorum;

5.4.6 REB members recusing themselves due to a conflict of interest are not counted toward quorum;

5.4.7 Only those REB members present (i.e., in person, or via videoconference or teleconference) at the Full Board meeting may participate in the deliberation and final decision regarding approval. Voting must not be asynchronous and cannot be anonymous;

5.4.8 Observers may be invited or permitted to attend REB meetings, subject to the agreement of the REB and execution of a *Confidentiality Agreement*. Observers must disclose any vested interest in, or scientific or management responsibility for, any applications being considered at the REB meeting;

5.4.9 Researchers may be invited or may be required to attend the REB meeting at which their application or response is discussed, in order to respond to questions and provide clarifications as needed;

5.4.10 If approval of an application is deferred by the Full Board, the Researcher may be invited to attend the REB meeting at which their response to the deferral notice is discussed, in order to respond to questions and provide clarifications as needed;

5.4.11 Any individual not listed on the official REB membership roster may not participate in the decisions of the REB.

5.5 Meeting Minute Preparation

5.5.1 The REB Office Personnel will draft the REB meeting minutes including key discussions, decisions, and votes;

5.5.2 The key REB discussions and decisions for submissions are recorded;

5.5.3 The REB's concerns, clarifications, and recommendations to the Researcher as discussed at the REB meeting are included in the REB review letter that is sent to the Researcher:

5.5.4 With agreement from REB members, the meeting may be recorded (on an encrypted device) as an administrative aid and to provide additional reference information for the generation of the final draft of the minutes. The recording should be deleted once the minutes have been approved;

5.5.5 The minutes are intended to reflect what the REB has decided, how it resolved controverted issues, and any determinations required by the regulations;

5.5.6 The draft minutes should be completed prior to the next REB meeting.

5.6 Meeting Minutes and Documentation

5.6.1 The minutes are made available at the next appropriate REB meeting, and members are requested to review the minutes and to note any errors for correction.

5.6.2 The REB meeting minutes include the following items:

- Date, place, and time the REB meeting commenced and adjourned,
- Names of REB members in attendance (present, teleconference, videoconference),
- Names of REB Office Personnel present at the meeting,
- Presence of observers,
- Use of ad hoc advisors and their specialty,
- List of declared conflicts of interest, a summary of any discussions, and the decision taken by the REB to address them (as applicable) or a note that none were declared,
- A summary of key discussions and controverted issues and their resolution for each submission, as applicable,
- The decisions taken by the REB regarding approval for each submission, as applicable,
- The basis for requiring changes or for disapproving submissions,
- Number of REB members in attendance for the review of each submission requiring a decision,
- REB member(s) recused in relation to conflicts of interest for each submission requiring a decision,
- Number(s) voting for, against, and abstaining in the event of a vote for each submission requiring a decision,
- Reference to any attachments to the agenda;

5.6.3 All REB meeting agendas and minutes are retained in the REB records;

5.6.4 The agendas, REB meeting minutes, and review documents are confidential and will not be released or made available unless required for inspection or auditing purposes.

6.0 REFERENCES

See References.

7.0 REVISION HISTORY

SOP Code	Effective Date	Summary of Changes
SOP302.001	15-Sept-2014	Original version
SOP302.002	08-Mar-2016	5.1.2: revision to the reporting criteria and notification of the REB for all Delegated reviews.
SOP302.003	08-Oct-2019	5.5.3: deletion of last sentence, “The information documented in the letter is included in the REB meeting minutes”; 5.7.1: deletion of ‘Names of REB members absent’
SOP302.004	15-May-2023	5.6: deletion of approval 5.6.1: deletion of ‘are presented at the meeting for REB approval’; inclusion of ‘members are requested to review the minutes and to note any errors for correction’ 5.6.2: deletion 5.6.3: deletion 5.7.1: deletion of ‘or’ replaced by ‘and’; ‘Number(s) voting for, against and abstaining....’
SOP302.005	14-Apr-2026	2.0: “policies” replaces “guidelines”. 5.2.3: deleted ‘the assigned reviewers will receive notification with a copy of the meeting agenda.’ 5.4.3: replaced ‘his/her’ with ‘their’. 5.4.4: updated to reflect common meeting options e.g. videoconference, in-person, or hybrid. 5.4.7: deleted. Full text is “Under unusual circumstances (e.g. public health alerts and quarantines), the REB Chair or Designee may, at his/her discretion, conduct an REB meeting with all REB members attending via simultaneous videoconference or teleconference; or using a hybrid of in-person and videoconference or teleconference. Everyone must have access to the review materials and quorum must be met.” 5.4.7: added “voting must not be asynchronous and cannot be anonymous”. 5.4.9: added ‘at which their application or response is

SOP Code	Effective Date	Summary of Changes
		discussed'; deleted 'subject to the agreement of the REB; clarified remaining wording. 5.4.10: New: "If approval of an application is deferred by the full board, the Researcher will be invited to attend the REB meeting at which their response to the deferral notice is discussed, in order to respond to questions and provide clarifications as needed.'

Title	Document Management
SOP Code	303.005
Effective Date	14-Apr-2026

Site Approvals

Name and Title (typed or printed)	Signature	Date dd/Mon/yyyy

1.0 PURPOSE

This standard operating procedure (SOP) describes the requirements for document management, including document retention and document archiving. This SOP applies to documents submitted to the Research Ethics Board (REB) for initial or for continuing review, as well as to all REB administrative documents, including those stored in electronic and cloud-based platforms.

2.0 SCOPE

This SOP pertains to REBs that review human Participant research in compliance with applicable regulations and policies.

3.0 RESPONSIBILITIES

All REB members and REB Office Personnel are responsible for ensuring that the requirements of this SOP are met.

This includes the institutional responsibility to ensure that systems used for document management (including cloud-based or software-as-a-service [SaaS] platforms) comply with security, confidentiality, and integrity standards applicable under Canadian and international guidance.

4.0 DEFINITIONS

See Glossary of Terms.

5.0 PROCEDURE

The REB office must retain all relevant records (e.g., documents reviewed and approved or disapproved, REB meeting minutes, correspondence with Researchers, written SOPs, and REB membership rosters) to provide a complete history of all actions related to the REB review and approval of submitted research. Such records must be retained for the length of time required by applicable regulations and guidelines.

Relevant records must be made accessible to authorized regulatory authorities, representatives of the organizations, Researchers, and funding agencies within a reasonable time upon request.

5.1 Research-Related Documents

5.1.1 The REB office retains the submission materials for all research that have been submitted for REB review and have been either approved, acknowledged, or disapproved;

5.1.2 Research-related documents include, but are not limited to, the following (as applicable):

- REB initial application form and all associated attachments;
- Correspondence between the REB and the Researcher, including REB approval letters, requests for modifications, etc.;
- Records of ongoing review activities such as,
    - Reportable event submissions, including reports of significant new findings, Data and Safety Monitoring Board (DSMB) reports, interim analysis reports, local adverse events, research deviations, privacy breaches, any investigations into allegations of serious or continuing non-compliance, and reports of inspections and audits by regulatory agencies or others,
    - Modifications to the application package including amendments to the research protocol and any other documents associated with the conduct of the study within the scope of REB review and approval;
- All other continuing review applications and documents associated with that review;
- Copies of correspondence between the REB and regulatory agencies;
- Reports of any complaints received by the REB and their resolution.

5.2 REB Administrative Documents

5.2.1 The REB office retains all administrative records related to the REB review activities;

5.2.2 REB administrative documents include, but are not limited to, the following:

- Agendas and minutes of all REB meetings;
- Submitted REB member reviews;
- REB member records:
  - Current and obsolete REB membership rosters, including alternate REB members,
  - CVs and training/qualification documentation of current and past REB members;
- Signed conflict of interest and confidentiality agreements;
- Current and obsolete SOPs;
- Current and obsolete documentation of the REB Chair or Designee's delegation of authority, responsibilities, or specific functions;
- Records of registration of the REB with the US Office of Human Research Protection, if applicable, and REB membership updates.

5.3 Document Access, Storage, and Archiving

5.3.1 Access to individual research projects and related documents is role-based to ensure that users only have access to documents and activities that are required by their role;

5.3.2 The REB records are housed securely with back-up, disaster, and recovery systems in place.

5.4 Confidentiality and Document Destruction

5.4.1 All submissions received by the REB are considered confidential and are accessible only to REB members (including the REB Chair and Vice-Chair), and the REB Office Personnel;

5.4.2 Relevant research projects and associated documents may be made accessible to members of regulatory agencies, or representatives of the Sponsor or Researcher for review. Access is limited to the applicable research and research-related submissions; REB records may be accessed by authorized institutional officials for audit, accreditation, or quality purposes. These records are not shared directly with Sponsors or service providers unless required by law or institutional policy.

5.4.3 The REB will retain required records (e.g., research-related or REB administrative documents, as applicable) for a minimum of 3 years after completion/termination of the trial, or for the maximum amount of time stipulated in any applicable governing regulation(s);

5.4.4 Any confidential materials in paper format in excess of the required documentation will be shredded.

5.5 Use of Electronic and Cloud-Based Application and Document Management Systems

5.5.1 Institutions are responsible for ensuring that any electronic or cloud-based systems used to create, store, manage, or archive REB records are fit for purpose and support the integrity, confidentiality, reliability, and accessibility of those records throughout their lifecycle;

5.5.2 Systems used for REB document management must be implemented and maintained in a manner consistent with applicable regulatory, ethical, and privacy requirements, including, where applicable, US FDA 21 CFR Part 11 (Electronic Records and Electronic Signatures), federal and provincial privacy legislation, and institutional information security policies;

5.5.3 Electronic systems must support the accuracy, completeness, and retrievability of REB records such that a complete history of REB review, decision-making, approvals, amendments, and archival actions can be reconstructed and made available for inspection, audit, or regulatory review as required;

5.5.4 Institutions must ensure that access to electronic REB systems is controlled and appropriate to users' roles and responsibilities, and that responsibilities for system administration, oversight, and record management are clearly defined;

5.5.5 Where audit trails or system logs are used, they must be retained and made available in accordance with applicable regulatory and institutional requirements;

5.5.6 Where REB records are stored or processed using cloud-based services, institutions are responsible for ensuring that data handling practices comply with applicable jurisdictional privacy requirements and that arrangements are in place to protect confidentiality, security, and regulatory access;

5.5.7 Institutions must have processes to ensure the continuity, retention, and accessibility of REB records in the event of system upgrades, migrations, vendor changes, or system decommissioning.

6.0 REFERENCES

See References.

7.0 REVISION HISTORY

SOP Code	Effective Date	Summary of Changes
SOP303.001	15-Sept-2014	Original version
SOP303.002	08-Mar-2016	5.3.2: revised to state securely housed with removal of the reference to an onsite location.
SOP303.003	08-Mar-2019	5.1.2: deletion of 'signed' from first bullet; 5.3.1: deletion of 'and to centre and Researcher profiles'; 5.4.1: deletion of 'as well as to organizational official(s)'; 5.4.2: deletion of 'other' and 'guest'
SOP303.004	15-May-2023	5.4.4: remove specific reference to HC retention requirement
SOP303.005	14-Apr-2026	1.0: added 'including those stored in electronic and cloud-based platforms' to the last sentence. 3.0: added 'This includes the institutional responsibility to ensure that systems used for document management (including cloud-based or software-as-a-service [SaaS] platforms) comply with security, confidentiality, and integrity standards applicable under Canadian and international guidance.' 5.1.2: revised bullet point 3, sub-bullet 2, from 'Modifications to the application including amendments to the research and/or any changes to the consent(s), participant materials or Investigator Brochures' to indicate 'application *package*' and to clarify 'any other documents associated with the conduct of the study within the scope of REB review and approval.' 5.1.2: bullet point 4 revised to '*All other* continuing review applications *and documents associated with that review'.* 5.5 : New section to align SOP 303 with current international and national standards for document management in research ethics oversight: ICH E6(R3) 2025: Computerised systems and TCPS2 (2022): Chapter 5, Privacy and Confidentiality

Title	Delegated Review
SOP Code	401.005
Effective Date	14-Apr-2026

Site Approvals

Name and Title (typed or printed)	Signature	Date dd/Mon/yyyy

1.0 PURPOSE

This standard operating procedure (SOP) describes the processes for determining when research meets the criteria for delegated ethics review and the associated Delegated review procedures.

2.0 SCOPE

This SOP pertains to Research Ethics Boards (REB) that review human Participant research in compliance with applicable regulations and policies.

3.0 RESPONSIBILITIES

All REB members and REB Office Personnel are responsible for ensuring that the requirements of this SOP are met.

The REB Chair or Designee is responsible for determining if research is eligible for Delegated review. In some circumstances, the REB Chair or Designee may delegate this task to qualified REB Office Personnel; however, the responsibility for oversight remains with the REB Chair or Designee.

The REB Chair or Designee or qualified REB member(s) is responsible for conducting the Delegated review.

4.0 DEFINITIONS

See Glossary of Terms.

5.0 PROCEDURE

REBs should adopt a proportionate approach to ethics assessment based on the general principle that the more invasive or harmful the proposed and ongoing research is, the greater the care should be in assessing the research. Full Board review by an REB should be the default requirement for all research involving human Participants unless the REB decides to authorize Delegated review based primarily on the harms that are expected to arise from the research.

While all research must be reviewed adequately, requirements for proportionate review allow the REB to provide a higher level of scrutiny, and correspondingly more protection, for the most ethically challenging research.

In practice, the proportionate review implies different levels of REB review for different research projects. The two levels typically used by REBs are Full Board review or Delegated review by one or more experienced REB members, as determined by the REB Chair or Designee.

5.1 Determination of Eligibility for Delegated Review

5.1.1 Full Board review is the default for most new research projects submitted to the REB; however, some research may be eligible for Delegated review;

5.1.2 Submissions that meet the following criteria may be eligible for Delegated review:

- Research projects that involve no more than minimal risk,
- Minor or minimal risk changes to approved research,
- Continuing review of approved minimal risk research,
- Continuing review of research that is more than minimal risk for which enrolment is closed permanently and all research-related interventions for all Participants are complete and the only remaining research activities are post-intervention activities or follow-up of Participants; or, where the remaining research activities are limited to data analysis; or, where no Participants have been enrolled and no additional risks have been identified,
- Continuing review of research that is more than minimal risk when there has been little or no modification of the research; and when there has been no increase in risk to or other ethical implications for Participants since the initial review by the full REB; if permissible under all applicable governing Regulations,

- The submission by the Researcher in response to the REB review as a condition of approval, as authorized by the Board,
- Changes to consent documents that do not affect the rights and welfare of research Participants or involve increased risk, or affect data integrity, or require significant changes in research procedures,
- Reportable events, including adverse events and safety updates such as reports from Data and Safety Monitoring Boards (DSMB);

5.1.3 The REB Chair or Designee may use Delegated review procedures for the review of other types of minor changes including, but not limited to, the following:

- Participant materials such as recruitment posters, scripts, diaries, validated questionnaires, and/or clinical trial identification/wallet cards,
- Authorized translations of English versions of documents previously approved by the REB;

5.1.4 The REB Chair or Designee may be authorized by the Full Board to use Delegated review procedures for the review of miscellaneous items such as changes to meeting minutes that previously received approval with conditions at a Full Board meeting;

5.1.5 When determining if initial review of research or modifications to previously approved research are eligible for Delegated review, the REB Chair or Designee will take into consideration the methods used to conduct the research, recruitment practices, Participant population, confidentiality of data, and all regulatory and ethics guidance requirements, as applicable.

5.2 Delegated Review Process

5.2.1 Qualified REB Office Personnel will perform an initial screening of the submission. Those submissions that meet a pre-defined set of criteria as determined by the REB may be forwarded for Delegated review. For all other submissions, the REB Chair or Designee will make the determination of whether the submission meets the criteria for Delegated review;

5.2.2 For research that meets the criteria, Delegated review may be conducted by the REB Chair, or by one or more qualified REB members as designated by the REB Chair or Designee;

5.2.3 The REB Chair or Designee reviewing the research under Delegated review must not have a conflict of interest in the research;

5.2.4 In reviewing the research under delegated procedures, the REB Chair or Designee may exercise all of the authorities of the REB, except that they may not

disapprove the research; the research may be disapproved only after it has been reviewed by the REB at a Full Board meeting;

5.2.5 REB member(s) conducting a Delegated review will contact the REB Chair or Designee to request the expertise of an ad hoc advisor, if applicable. Ad hoc advisors may not participate in the final decision regarding approval of the research;

5.2.6 If the REB Chair or Designee subsequently determines that the level of risk for the submission is greater than minimal, the submission will be referred to a Full Board meeting for review;

5.2.7 The REB Chair or Designee will record the decision regarding the designation of the research (i.e., either requiring Full Board or Delegated review) and the outcome of the review. The responsible REB Office Personnel may issue the review or decision letter.

5.3 Notification of the REB

5.3.1 At its next Full Board meeting, the REB will be informed of research that was reviewed and approved using Delegated review procedures.

5.4 Documentation

5.4.1 The type of REB review conducted (i.e., Full Board or Delegated) is documented in the REB records and noted in the decision letter issued to the Researcher;

5.4.2 A report of research ethics applications approved through the Delegated review procedure between Full Board meetings will be presented at the Full Board meeting.

6.0 REFERENCES

See References.

7.0 REVISION HISTORY

SOP Code	Effective Date	Summary of Changes
SOP401.001	15-Sept-2014	Original version
SOP401.002	08-Mar-2016	No revisions needed
SOP401.003	08-Oct-2019	5.4.2: deletion of 'meeting agendas and minutes will include', replaced with 'will be provided with'
SOP401.004	15-May-2023	No revisions needed
SOP401.005	14-Apr-2026	2.0: changed 'guidelines' to 'policies' 5.1: changed 'qualification' to 'eligibility. 5.2.4: changed 'he/she' to 'they'. 5.4.2: simplified and clarified "The REB will be provided with a list of submissions that were reviewed and approved using Delegated review procedures from the time that the agenda for the previous REB meeting was issued."

Title	REB Review Decisions
SOP Code	402.005
Effective Date	14-Apr-2026

Site Approvals

Name and Title (typed or printed)	Signature	Date dd/Mon/yyyy

1.0 PURPOSE

This standard operating procedure (SOP) describes the decisions that the Research Ethics Board (REB) may make resulting from its review of proposed research for ethical acceptability.

2.0 SCOPE

This SOP applies to REBs that review human Participant research in compliance with applicable regulations and policies.

3.0 RESPONSIBILITIES

All REB members and REB Office Personnel are responsible for ensuring that the requirements of this SOP are met.

The REB Chair or Designee is responsible for ensuring that a decision is made for every submission that is reviewed by the REB, that the decision is clearly understood, and that the delegation of responsibility for considering any further information prior to issuing approval is clearly agreed upon.

4.0 DEFINITIONS

See Glossary of Terms.

5.0 PROCEDURE

As a result of its review, an REB has the authority to approve, disapprove, or to require modifications to submitted research. If there are questions that must be addressed prior to a determination, the REB may defer its decision. When the Full Board review procedure is used, decisions will be made by consensus or a majority vote of the REB members who are present at a Full Board meeting at which there is a quorum.

REB members with a conflict of interest in the research under review must not participate in the deliberations or in the vote of the REB (if applicable), in accordance with the REB and organization's conflict of interest policies.

When the Delegated review procedure is used, the REB Chair and/or REB member(s) who are assigned to the review can decide to approve the research or to request revisions to the research; the decision to disapprove the research must be made by the Full Board.

Researchers have the right to request reconsideration of the REB's decisions and to appeal the decision of the REB.

5.1 REB Decisions

5.1.1 REB decisions are made either by consensus, or a majority vote of the REB members present at a Full Board meeting, with the exception of those who have recused themselves in accordance with the conflict of interest policies.

5.1.2 The REB should reach one of the following decisions as a result of its review of research submitted for initial or for continuing review:

- **Approval** (approve the application package as submitted, :
  - When an acceptable risk/benefit ratio exists and the regulatory criteria required for approval are satisfied, the research may be approved as submitted,
  - The approval date is defined according to local REB procedure,
  - The expiry date of the REB approval is set by the REB according to the degree of risk and local REB procedure but must not be set for more than one year from the approval date.

- **Approval with Modifications/Clarifications**:
  - When an acceptable risk/benefit ratio exists, and the regulatory criteria required for approval are satisfied, but the REB members require modification(s) or clarification(s) to any aspect of the application,or further information to secure approval, the REB may recommend "Approval with Modifications/Clarifications",

- When the REB recommends “Approval with Modifications/Clarifications”, the REB Chair or Designee should ensure that the additional information, modifications, or clarifications required are identified at the REB meeting and that the procedures for reviewing the additional information and issuing the approval are clear. The responsibilities for additional review and the decision regarding approval conditions should be delegated to one of the following:
  - The REB Chair alone,
  - The REB Chair and one or more named REB members that were present at the REB meeting or who submitted written comments on the application,
  - A sub-group of the REB members designated by the REB Chair or Designee or by the REB,
  - A designated REB member or members with sufficient knowledge and experience regarding the research and the regulations.
- In deciding the procedures to be followed, the REB should consider the significance of the requested additional information or modifications and the expertise necessary to assess it. Where the information or modifications are straightforward, it is acceptable to delegate the consideration of that material to the REB Chair or Designee alone,
- Where the additional information/modification is technical (e.g., statistical clarifications), the REB Chair or Designee should review the information with consideration given to involving other REB members, such as the lead reviewer(s) or relevant expert member(s),
- If the Researcher’s response is deemed complete and satisfactory, approval can be issued,
- If the Researcher’s response is incomplete and does not fully address the matters raised, requests for further information, modifications, or clarifications should be sent to the Researcher,
- The reviewers may decide upon reviewing the Researcher’s response that the decision should be deferred and that the application and the Researcher’s response materials should be reviewed at a subsequent Full Board meeting (see ‘Deferral’ process below),
- The approval date is defined according to local REB procedures. The expiry date of the REB approval is set by the REB according to the degree of risk and local REB procedure but must not be set for more than one year from the approval date. The approval letter is not issued until all of the conditions for approval have been met.

- **Deferral** (defer decision-making on the application and continue the deliberation of the application at a future Full Board meeting):
  - The REB will defer its decision to a subsequent Full Board meeting when significant questions are raised during its review of the research and/or

when the criteria required for approval have not been met,
- The REB Chair or designee should ensure that all additional information, modifications or clarifications that are required are specifically identified at the Full Board meeting,
- The research and the Researcher's response materials shall be reviewed at a Full Board meeting,
- Upon consideration of the research along with the response from the Researcher, at the Full Board meeting, the REB should issue its final decision (approved, approved with modifications, deferral, or disapproved),
- Researcher responses must be received and reviewed at a Full Board meeting. The Approval date is defined according to local REB procedures. The expiry date of the REB approval is set by the REB according to the degree of risk and local REB procedure but must not be set for more than one year from the approval dateThe approval letter is not issued until all the conditions for approval have been met.

- **Disapproval**:
  - The REB may disapprove the research when it fails to meet the ethical standards for approval and where revision is unlikely to enable the REB to reach a positive determination,
  - Disapproval cannot be decided through the Delegated review mechanism. If the recommendation under Delegated review is to disapprove the research, a final decision must be made by the REB at a Full Board meeting,
  - The REB Chair or designee should ensure that the reasons for the disapproval are identified at the Full Board meeting for communication to the Researcher,
  - If the research is disapproved, the reasons for disapproval will be communicated to the Researcher and the Researcher will be given an opportunity to respond in person or in writing.

5.1.3 **Delegated Reviews**:

- When the research qualifies for Delegated review, the reviewer(s) has the authority to approve the application, to require modifications to any aspect of the application, or to request clarification, or further information before considering it eligible for ethics approval. The reviewer(s) may also refer the applications as submitted for a review at a Full Board meeting,
- When Delegated review procedures are followed, approval is considered as the day the research is approved by the REB Chair or Designee as well as all other designated reviewer(s), if applicable. The expiry date of the REB approval must not be set for more than one year d from this date; the

approval letter is not issued until all of the conditions for approval have been met,

- If the research cannot be approved through the Delegated review mechanism, it must be reviewed at a Full Board meeting.

5.2 Reconsideration and Appeal of REB Decisions

5.2.1 A Researcher may appeal the decision of the REB if the disagreement between the Researcher/applicant and the REB cannot be resolved through a reconsideration process at a Full Board meeting at which the Researcher/ applicant shall have the right to be heard;

5.2.2 The Researcher must justify the grounds on which a reconsideration of the decision is requested. An appeal may be launched only for procedural or substantive reasons, and a final decision after reconsideration must be issued by the REB prior to the initiation of an appeal process;

5.2.3 Appeals are conducted in accordance with the established organizational policy. The organization at which the appeal will take place will be determined on a case-by-case basis by the REB in consultation with the Researcher (and their affiliated organization);

5.2.4 The Appeal committee shall have the authority to review negative decisions made by the REB and in so doing it may approve, disapprove, or request modifications to the research proposal. Its decision shall be final and shall be communicated to the Researcher and the REB in writing.

5.3 Documenting REB Decisions

5.3.1 The REB meeting minutes will satisfy the applicable requirements;

5.3.2 The REB shall notify the Researcher in writing of its decision to approve or disapprove the proposed research, or of modifications/clarifications required to secure approval of the research;

5.3.3 If the REB defers its decision, the letter to the Researcher should include the issues of concern and what further information is required;

5.3.4 The final approval letter should include standard conditions of approval to which the Researcher must adhere;

5.3.5 When the decision to approve a submission is recorded on behalf of the Full Board, or when a Delegated reviewer electronically signs off on a decision (under Delegated review procedures), the notification or correspondence to the Researcher may be issued by the REB Office Personnel.

6.0 REFERENCES

See References.

7.0 REVISION HISTORY

SOP Code	Effective Date	Summary of Changes
SOP402.001	15-Sept-2014	Original version
SOP402.002	08-Mar-2016	No revisions needed
SOP402.003	08-Oct-2019	5.1.1: deletion of, 'The Chair abstains from voting except to break a tie vote.'
SOP402.004	15-May-2023	No revisions needed
SOP402.005	14-Apr-2026	2.0: changed 'guidelines' to 'policies'; 5.1.2: changed 'application including the consent form' to 'application package'; 5.1.2: changed 'The expiry date of the REB Approval is calculated from this date.' to 'The expiry date is set by the REB according to the degree of risk and local REB procedure but must not be set for more than one year from the approval date'. There are 3 instances of this language. 5.1.3: revised 'The expiry date is calculated from this date' to 'The expiry date must not be set for more than one year'.

Title	Initial Review – Criteria for REB Approval
SOP Code	403.005
Effective Date	14-Apr-2026

Site Approvals

Name and Title (typed or printed)	Signature	Date dd/Mon/yyyy

1.0 PURPOSE

This standard operating procedure (SOP) describes the minimum requirements that research proposals involving human Participants must meet in order to be approved by the Research Ethics Board (REB), independent of the review pathway (i.e., Full Board or Delegated review).

2.0 SCOPE

This SOP applies to REBs that review human Participant research in compliance with applicable regulations and policies.

3.0 RESPONSIBILITIES

All REB members and REB Office Personnel are responsible for ensuring that the requirements of this SOP are met.

The REB members are responsible for determining whether the research meets the criteria for approval.

4.0 DEFINITIONS

See Glossary of Terms.

5.0 PROCEDURE

All research involving human Participants must meet certain criteria before REB approval may be granted. Initial REB approval of the research is based on the assessment of a complete submission to the REB. The REB and/or REB Office Personnel may consult the Researcher for additional information as necessary.

Following initial review of the research, the REB should be prepared to make a determination as to the approvability of the research.

In addition to REB approval, the requirements of the organization where the research will be conducted must also be met before the research can begin (e.g., department approvals, adequate resources, etc.).

5.1 Minimal Criteria for Approval of Research

In order for the research to receive REB approval, the REB will take the following into consideration:

5.1.1 That the Researcher has the qualifications to conduct the research;

5.1.2 Any potential conflicts of interest are declared and are managed appropriately to prevent any compromises to the safety or well-being of the Participants or to the integrity of the data;

5.1.3 There is a state of clinical equipoise when there is a comparison of two or more treatment arms;

5.1.4 The research will generate knowledge that could be Generalized and lead to improvements in health or well-being;

5.1.5 The methodology is scientifically sound and capable of answering the research question;

5.1.6 The risks to Participants are minimized by:

- Using procedures that are consistent with sound research design and that do not unnecessarily expose Participants to risk, and
- By using procedures already being performed on the Participants for diagnostic or treatment purposes whenever appropriate;

5.1.7 The risks to Participants are reasonable in relation to the anticipated benefits, if any, and the importance of the knowledge that will be generated;

5.1.8 The selection of Participants is equitable. In making this assessment, the REB

will take into account the purpose of the research and the research setting. The REB will consider the scientific and ethical reasons for including vulnerable populations, if applicable;

5.1.9 There are sound scientific and ethical reasons for excluding classes of persons who might benefit from the research;

5.1.10 When some or all of the Participants, such as children, prisoners, the elderly, pregnant women, those with mental health issues, and those with diminished capacity for self-determination may be vulnerable to coercion or undue influence, in the context of research, additional safeguards have been included in the research, and in the REB review process to protect the rights and welfare of these Participants;

5.1.11 The amount and method of payment to Participants is appropriate, to ensure that there is no undue influence and that Participants are reimbursed fairly and not put at any financial disadvantage for the time and inconvenience of participation in research Payments and reimbursement must be clearly described to Participants (including method, amounts, and schedule);

5.1.12 Informed consent will be sought from each prospective Participant or from the Participant's legally authorized representative, in accordance with and to the extent required, by applicable regulations and policies;

5.1.13 The informed consent form will accurately explain the research and contain the required elements of consent;

5.1.14 The informed consent process will be appropriately documented in accordance with the relevant regulations;

5.1.15 There will be provisions for on-going data and safety monitoring procedures that are appropriate to the size, complexity, phase, and level of risk of the research. The REB may recommend the use of a Data and Safety Monitoring Board (DSMB) to enhance Participant protection;

5.1.16 There will be adequate provisions to protect the privacy of Participants and to maintain data confidentiality;

5.1.17 There will be adequate provisions for continued access to the agent or device or an adequate replacement of the test agent after the research is complete, when appropriate;

5.1.18 There will be adequate provisions for the timely publication and dissemination of the research results, including sharing results with Participants in a format that is suitable for them (e.g. lay language summary);

5.1.19 If applicable, evidence that the research has been or will be registered via an internationally recognized clinical trial registry.

5.2 Additional Criteria

5.2.1 Studies proposing access to or collection of personal information require consideration of additional items to ensure the protection of the privacy of the personal information and to determine whether appropriate privacy legislation is adhered to;

5.2.2 Additional criteria for research involving Indigenous peoples in Canada, or research on materials related to human reproduction, genetic research, children, prisoners, or pregnant women shall be applied when applicable in accordance with governing principles and/or Regulations.

5.3 Length of Approval Period

5.3.1 The REB shall review research at periods appropriate to the degree of risk and at least annually;

5.3.2 The REB may require review more often than annually when there is a high degree of risk to Participants relative to the population;

5.3.3 The REB may consider reviewing the research more often than annually as required by the continuing review procedures.

6.0 REFERENCES

See References.

7.0 REVISION HISTORY

SOP Code	Effective Date	Summary of Changes
SOP403.001	15-Sept-2014	Original version
SOP403.002	08-Mar-2016	No revisions needed
SOP403.003	08-Oct-2019	5.1.1: deletion of ' The application has been signed by the Researcher and, if applicable, by a designated Organizational Official, indicating'; 5.1.10: addition of ….who may be vulnerable 'in the context of research'; 5.1.19: First sentence changed to 'If applicable, **evidence that** the research has been or will be registered via an internationally recognized clinical trial registry; deletion of 'and a registration number has been/will be submitted to the REB. If the research is not yet registered, the researcher shall provide the REB with the registration number upon registration.'; 5.2.2: replaced the word Aboriginal with Indigenous
SOP403.004	15-May-2023	No revisions needed
SOP403.005	14-Apr-2026	2.0 and 5.1.12 'guidelines' replaced by 'policies'; 5.1.11, added language about fair reimbursement of research participants for research-related expenses; 5.1.18 added 'sharing results with participants in a format that is suitable for them, e.g. lay language.'

Title	Ongoing REB Review Activities
SOP Code	404.005
Effective Date	14-Apr-2026

Site Approvals

Name and Title (typed or printed)	Signature	Date dd/Mon/yyyy

1.0 PURPOSE

This standard operating procedure (SOP) describes the procedures for the ongoing review activities that occur after the initial Research Ethics Board (REB) approval and prior to the formally scheduled continuing review of the research project.

2.0 SCOPE

This SOP applies to REBs that review human Participant research in compliance with applicable regulations and policies.

3.0 RESPONSIBILITIES

All REB members, REB Office Personnel, and Researchers are responsible for ensuring that the requirements of this SOP are met.

The Researcher is responsible for reporting to the REB any new information generated throughout the course of the research that might affect the rights, safety, and well-being of research Participants, including Reportable events that meet the reporting criteria as per this SOP and the Glossary.

The Researcher is responsible for reporting to the REB any information about the conduct of the research that could affect the rights, safety, and well-being of research Participants, including information about any serious or continuing Non-compliance.

When action is taken to ensure the protection of the rights, safety, and well-being of

Participants (e.g., for an Unanticipated problem involving risks to Participants or others) the REB is responsible for reporting to the Researcher and the Organizational Official(s) and has the authority to notify the Sponsor and/or the appropriate regulatory authorities of any events that meet the reporting criteria. The REB may delegate regulatory authority reporting (as applicable) to the organization.

The REB Chair or Designee is responsible for reviewing all Reportable events submitted to the REB as well as any proposed Amendments to the research, and for determining the type of review (i.e., delegated or Full Board) or action required.

The REB members are responsible for reviewing any new information, Reportable events or proposed Amendments that are assigned to them or that are assigned to a Full Board meeting, and for recommending the appropriate course of action.

4.0 DEFINITIONS

See Glossary of Terms.

5.0 PROCEDURE

It may be that the real risk/benefit ratio can be evaluated only after the research has begun; therefore, in addition to the formally scheduled continuing review, the REB must receive and review any new information generated throughout the course of the research that might affect the rights, safety, and well-being of research Participants. Such information may include:

- Modifications or changes to the previously approved research,
- Reports of Unanticipated problems involving risks to Participants or others,
- Reports of any serious or continuing Non-compliance,
- Reports of any changes significantly affecting the conduct of the research or increasing the risk to research Participants,
- Results of any interim analysis or Data and Safety Monitoring Board (DSMB) assessments,
- Deviations to the previously approved research,
- Adverse events that meet the reporting criteria,
- Reports of any Privacy breaches,
- Summary reports of any audits and Inspections,
- Any other new information that may adversely affect the safety of research Participants or the conduct of the research,

Modifications to the approved research may not be initiated without prior REB review and approval, except where necessary, to eliminate apparent immediate hazards to

human Participants. If changes are made to eliminate immediate hazards, the Researcher must notify the REB immediately.

5.1 Amendments to the Approved Research

5.1.1 The Researcher is responsible for submitting to the REB any changes to the approved research as an amendment application. Changes to the approved research include modifications to research-related documents such as the consent form or other Participant materials (e.g., wallet cards, diary cards, recruitment materials), the Investigator Brochure (IB) or product monograph (PM), and administrative changes such as a change in study team members, etc.;

5.1.2 When the Amendment includes a change to the consent form, the Researcher must indicate their recommendation for the provision of the new information to current and/or past research Participants;

5.1.3 The Researcher must indicate the type of review being requested (i.e., Full Board, Delegated review, or acknowledgement for a minor correction). Supporting correspondence documentation and/or background information may be appended to the Amendment submission;

5.1.4 The REB Chair or Designee reviews the Amendment to determine the appropriate level of REB review required (i.e., Full Board or Delegated review);

5.1.5 The REB Chair or Designee also may use Delegated review procedures for review of Amendments when the conditions are met;

5.1.6 If the proposed change represents more than Minimal risk, it must be reviewed by the REB at a Full Board meeting. Amendments that may be classified as more than Minimal risk may include:

- Addition of genetic testing, new genetic tests, or tissue banking where genetic testing may or will be performed,
- Addition of an open label extension phase following a randomized trial,
- Emergency Amendments that arise because of Participant safety and may include, but are not limited to:
  1. A change in drug dosing/duration of exposure,
  2. A change in recruitment that may affect Confidentiality or the perception of coercion,
  3. A change in experimental procedure or research population;

5.1.7 For Amendments requiring Full Board review, the responsible REB Office Personnel assigns the Amendment to the next available Full Board meeting. For Amendments that meet the criteria for Delegated review, the responsible REB Office Personnel will forward the Amendment to the designated Reviewer;

5.1.8 When an Amendment involves a revised consent, the REB will consider the recommendations of the Researcher in determining if, how, and when the new information should be provided to the research Participants and whether re-consent is required;

5.1.9 The REB must find that the criteria for approval are still met in order to approve the Amendment;

5.1.10 The amended research may not be implemented prior to the REB review and approval, except when necessary to eliminate immediate hazards to Participants.

5.2 Reportable Events

5.2.1 The Researcher is responsible for submitting Reportable events that meet the REB's reporting criteria according to the local procedures;

5.2.2 Local Adverse Events (AEs): Researchers must report local AEs to the REB in a timely manner if, in the opinion of the Researcher, the local event meets the definition of a Unanticipated Problem.

- All reports submitted to the REB must have all research Participant identifiers removed (Participant research number only),
- Once a local AE is acknowledged by the REB, subsequent important follow-up reports related to the AE should be submitted when relevant information is available as an AE update(s). All initial and subsequent follow-up reports will be retained with the Reportable event;

5.2.3 Non-Local (External) AEs: Upon receipt of an external AE, a periodic safety update, or a safety summary report, the Researcher must determine if it meets the REB reporting criteria:

- Non-local AE reports are reportable to the REB, if in the opinion of the Researcher, it meets the definition of an Unanticipated problem AND requires a change to the research and/or informed consent form and/or requires immediate notification to Participants for safety reasons,
- The report submitted to the REB must include **all** of the following information:
  - The description of the serious and unexpected event(s),
  - All previous safety reports concerning similar AEs,
  - An analysis of the significance of the current AE(s) in light of the previous reports, **and**

- The proposed research changes, informed consent form or other study document changes, or other corrective actions to be taken by the Sponsor in response to the event(s),

- The individual AE reports, periodic safety updates, or safety summary reports that meet the reporting criteria must be submitted to the REB in a timely manner,
- Non-serious adverse drug reactions for clinical trials that do not require Health Canada authorization do not need to be reported;

5.2.4 Other Reportable Events: The Researcher is responsible for reporting other events or findings to the REB, such as:

- Any new information (e.g., Sponsor's safety notice or action letter) that would cause the Sponsor to modify the IB, the research protocol, the consent form or other study documents, or that would prompt other action by the REB to ensure protection of research Participants,
- Any changes to the risks or potential benefits of the research, such as:
  - An interim analysis indicates that Participants have a lower rate of response to treatment than initially expected,
  - Safety monitoring indicates that a particular side effect is more severe, or more frequent than initially expected,
  - Information is published from another research project that shows that an arm of the research is of no therapeutic value,
- A change in Health Canada or FDA safety labeling or withdrawal from marketing of a drug, device, health product, genetic therapy or biologic used in research,
- The Researcher is also responsible for submitting other types of reportable events to the REB, such as:
  - DSMB reports,
  - Interim analysis results,
  - Any unanticipated problems or other events that could significantly impact the overall conduct of the research or alter the REB's approval or favorable opinion to continue the research,
- A change to the research that was initiated without prior REB review to eliminate an apparent immediate risk to a research Participant,
- Any Unanticipated problems or other events that could significantly impact the conduct of the research at the site (e.g., concerns of non-compliance),
- Other Reportable events must be submitted to the REB within a timely manner;

5.2.5 Deviations to Previously Approved Research: The Researcher must report any deviations to the REB that meet the following reporting criteria:

- Deviations that in the opinion of the Researcher jeopardize the safety of research Participants, or that jeopardize the research efficacy or data integrity,
- Any Sponsor-approved waivers to the Participant eligibility criteria,
- Any change in the approved process for obtaining consent (e.g., improper translation, current consent formnot implemented),
- Any deviations that lead to a serious adverse event (SAE),
- Deviations must be reported within a time frame specified by the REB; deviations that lead to an SAE should be reported with a timely manner;

5.2.6 Privacy Breaches: The Researcher must report to the REB any unauthorized collection, use, or disclosure of personal information (PI) including, but not limited to:

- The collection, use, and disclosure of PI that is not in compliance with the jurisdictional legislation or its regulation,
- Circumstances where PI is stolen, lost, subject to unauthorized use or disclosure, or where records of PI are subjected to unauthorized copying, modifications, or disposal,
- In the Researcher context, any unauthorized collection, use or disclosure of PI that was not authorized under the research and approved in the plan that was submitted to the REB,

The breach must be reported to the REB and to the appropriate Organizational Official as soon as the Researcher becomes aware of the breach;

5.2.7 Audit or Inspection Findings: The Researcher must report to the REB a summary of any relevant audit or Inspection findings following a Health Canada inspection, an FDA or other regulatory audit, an internal quality assurance (QA) audit or other audits at the site;

5.2.8 Research Participant Complaint: The Researcher must report to the REB, and to the organization if required by local procedures, a complaint from a Participant when the Participant reports concerns about their rights as a research Participant or about ethical issues related to the research.

5.3 Review of Reportable Events by the REB

5.3.1. The responsible REB Office Personnel will screen the Reportable event submission for completeness;

5.3.2. Privacy breaches are reviewed by the REB Chair or Designee, and any recommendations including remedial action are determined in consultation with the organization's privacy office. The Privacy breach report is forwarded to the

REB Chair or Designee for review and final acknowledgement;

5.3.3. The REB Office Personnel may route the submission back to the Researcher to request clarifications, missing documents, or additional information;

5.3.4. The REB Office Personnel will forward the submission to the designated REB Reviewer(s);

5.3.5. The assigned REB Reviewer(s) will conduct a review of the report and determine if any action or follow-up is required;

5.3.6. The assigned Reviewer(s) may request further information from the Researcher;

5.3.7. When reviewing a reportable event, the REB should:

- Assess the appropriateness of any proposed corrective or preventative measures by the Sponsor and/or Researcher,
- Consider any additional appropriate measures that may or may not have been identified or proposed by the Sponsor and/or Researcher,
- Consider whether the affected research still satisfies the requirements for REB approval; in particular whether risks to research Participants are still minimized and reasonable in relation to the anticipated benefits, if any, to the research Participants and the importance of the knowledge that may reasonably be expected to result,
- Consider whether some or all of the research Participants should be notified of the events (i.e., if it may affect the Participant's willingness to continue participation in the research), and
- Consider whether suspension or termination of the ethics approval of the research is warranted;

5.3.8. If the event does not raise concerns and does not appear to involve risks to research Participants or others, the REB Chair or Designee acknowledges the report, and no further action is required;

5.3.9. If the REB Chair or Designee determines that the event meets the criteria for an unanticipated problem, and if immediate action is required to protect the safety of research Participants, they may suspend ethics approval of the research pending review by the Full Board, providing the justification for such action is documented;

5.3.10. If the event raises concerns or involves risk to research Participants such that REB action may be required, the item is added to the agenda of the next Full Board meeting;

5.3.11. For Reportable events reviewed at a Full Board meeting, the REB determines whether further action is required. Possible actions that could be taken by the REB include, but are not limited to:

- Placing a hold on the research pending receipt of further information from the Researcher,
- Requesting modifications to the research,
- Requesting modifications to the consent form,
- Providing additional information to past Participants,
- Notifying current Participants when such information might affect the Participants willingness to continue to take part in the research, and requiring that current Participants re-consent for ongoing participation,
- Altering the frequency of Continuing review,
- Observing the research or the consent process,
- Requiring additional training of the Researcher and research staff,
- Termination or Suspension of the research,
- If the REB determines that the event does not raise concerns about risks to research Participants, the REB may decide that no further action needs to be taken;

5.3.12. When action is taken to ensure the protection of the rights, safety, and well-being of Participants (e.g., for an Unanticipated problem involving risks to Participants or others) the REB Chair or Designee is responsible for reporting to the Researcher and the Organizational Official(s) and has the authority to notify the Sponsor and the appropriate regulatory authorities (as applicable). The REB may delegate regulatory authority reporting (as applicable) to the organization.

6.0 REFERENCES

See References.

7.0 REVISION HISTORY

SOP Code	Effective Date	Summary of Changes
SOP404.001	15-Sept-2014	Original version
SOP404.002	08-Mar-2016	No revisions needed
SOP404.003	08- Oct-2019	5.2.2: Local AEs heading: 'within a time frame specified by the REB', changed to 'in a timely manner';

SOP Code	Effective Date	Summary of Changes
		Second bullet deleted: 'The completed sponsor's serious adverse event (SAE) form (if applicable), must be appended to the reportable event form'; Fourth bullet deleted: 'The completed sponsor's serious adverse event (SAE) form (if applicable), must be signed by the Researcher or medical designee'; Final bullet first sentence changes bolded: 'Once a local SAE is acknowledged by the REB, subsequent important follow-up reports related to the SAE should be submitted when '**relevant information is available'** as a SAE update(s); delete; 'The sponsor's follow up reporting form(s) signed by the Researcher or designee must be appended to the updated reportable event.'; 5.2.3: last bullet: 'within a time frame specified by the REB', changed to 'in a timely manner'; 5.2.4: last bullet: 'within a time frame specified by the REB', changed to 'in a timely manner'; 5.2.5: last bullet: 'within a time frame specified by the REB', changed to 'in a timely manner'; 5.2.6: deletion of 'if applicable' in the final sentence
SOP404.004	15-May-2023	No revisions needed
SOP404.005	14-Apr-2026	2.0: changed 'guidelines' to 'policies; 3.0: Added 'and the Glossary'; 5.1.1: added 'application' to the end of the first sentence; added 'research-related documents' to clarify that amendments are not limited to the types of documents listed here; clarified 'administrative' changes such as changes to the 'study team' in place of 'changes to the Researcher'. 5.2.2: minor edits for syntax; 5.2.3: added 'Non-serious adverse drug reactions for clinical trials that do not require a Health Canada authorization do not need to be reported.' 5.2.4: 1st bullet, clarified 'the research *protocol*'; added 'or other study documents'; changed 'immediate hazard' to 'immediate risk'; 5.2.5: spelled out 'consent form' in place of 'ICF'.

Title	Continuing Review
SOP Code	405.005
Effective Date	14-Apr-2026

Site Approvals

Name and Title (typed or printed)	Signature	Date dd/Mon/yyyy

1.0 PURPOSE

This standard operating procedure (SOP) describes the procedures for the continuing review of research that is overseen by the Research Ethics Board (REB), and the criteria for continued REB approval.

2.0 SCOPE

This SOP pertains to REBs that review human Participant research in compliance with applicable regulations and policies.

3.0 RESPONSIBILITIES

All REB members and REB Office Personnel are responsible for ensuring that the requirements of this SOP are met.

The REB Chair or Designee and the assigned REB reviewer are responsible for conducting an in-depth review of all submitted materials for their assigned research projects.

All other REB members are responsible for reviewing the submitted materials for each research application in enough depth to be prepared to discuss the research meaningfully at a Full Board meeting.

4.0 DEFINITIONS

See Glossary of Terms.

5.0 PROCEDURE

REBs must establish procedures for conducting the continuing review of approved research involving human Participants at intervals appropriate to the degree of risk, but not less than once a year. Periodic review of research activities is necessary to determine whether approval should be continued or withdrawn.

5.1 Continuing Review by the Full Board

5.1.1 The Researcher is required to submit an application for continuing review of research at a frequency to be determined by the REB and which will be defined at the time of the initial approval of the research, or as otherwise revised;

5.1.2 At a minimum, the REB requires that an application for continuing review be submitted once per year until all of the data has been collected, all contact with research Participants has concluded, and the closure of the research has been acknowledged by the REB;

5.1.3 The REB may determine that the research requires continuing review more frequently than once per year by considering the following:

- The nature of any risks posed by the research,
- The degree of uncertainty regarding the risks involved,
- The vulnerability of the Participant population,
- The projected rate of enrolment and estimated research closure date,
- Whether the research involves novel interventions,
- The REB believes that more frequent review is required;

5.1.4 Continuing review applications are due by the deadline for the applicable REB meeting (i.e., the expiry date must be on or after the REB meeting date and prior to the date of the subsequent REB meeting), regardless of the type of review they may undergo;

5.1.5 To assist the Researchers in submitting on time, a courtesy reminder(s) prior to the expiry date may be generated;

5.1.6 The responsible REB Office Personnel reviews the application for completeness, and requests any clarifications, missing documents, or other information from the Researcher, as applicable;

5.1.7 The REB may request verification from sources other than the Investigator to ensure that no material changes have occurred since the previous REB review. For example:

- Based on the results of a previous audit or inspection (internal or external),
- Suspected non-compliance,
- Studies involving vulnerable populations,
- Studies involving a potentially high risk to Participants,
- Suspected or reported protocol deviations,
- Participant or Research Staff complaints,
- Any other situation that the REB deems appropriate;

5.1.8 The responsible REB Office Personnel will assign the application to the agenda of the next REB meeting if the research meets the criteria for Full Board review;

5.1.9 A summary report of the continuing review applications assigned to the REB meeting may be attached to the REB meeting agenda;

5.1.10 For research that meets the criteria for Full Board review, the REB will discuss the research at a Full Board meeting and will make a decision regarding the continued approval of the research, as well as any other additional determinations regarding the conduct of the research, as applicable.

5.2 Continuing Review by Delegated Review Procedures

5.2.1 When the research receives initial approval via Delegated review it may also undergo Delegated review at the time of continuing review;

5.2.2 Research that was previously reviewed by the Full Board may also be reviewed at the time of continuing review using Delegated review procedures if the conditions are met;

5.2.3 The responsible REB Office Personnel reviews the continuing review application for completeness, and requests any clarifications or other information as applicable;

5.2.4 The responsible REB Office Personnel will forward the application to the appropriate REB reviewer;

5.2.5 The reviewer may request additional information or clarification, as necessary, and will make a decision regarding the continued approval of the research and the continued conduct of the research;

5.2.6 Upon reviewing an application that was sent for Delegated review, if the reviewer determines that the risks are now greater than minimal, the reviewer will refer the application for review by the Full Board.

5.3 REB Determinations

5.3.1 To grant a continuation of the approval of the research the REB must determine that:

- There have been no material changes to the research or to the informed consent form that have not been previously submitted and approved,
- There is no new conflict of interest or new information that has emerged that might adversely affect the safety or the well-being of research Participants,
- Risks to research Participants are minimized and reasonable in relation to the anticipated benefits,
- Selection of research Participants is equitable,
- Informed consent processes continue to be appropriate and documented,
- Adequate provisions are in place for monitoring and data protection to ensure the safety and privacy of Participants, and confidentiality and integrity of the data,
- Any complaints from research Participants have been followed up appropriately;

5.3.2 The REB may also make additional determinations, including:

- Request changes to the informed consent form(s),
- Request changes for the continuing review interval (based on risks),
- Impose special precautions (e.g., frequency of monitoring, the requirement for interim reports, or duration of approval period),
- Require modifications to the research,
- Suspend or terminate REB approval.

5.4 Continuing Review Applications Not Received by the Expiry Date

5.4.1 If an application for continuing review is not submitted by the expiry date, a warning or suspension notice will be issued to the Researcher. When suspended, the Researcher must suspend all research activities as specified by the REB. The responsible REB Office Personnel will follow-up with the Researcher to ensure that the application for continuing review is submitted as soon as possible;

5.4.2 In the event of a lapse in approval, the Researcher is responsible for notifying the REB if there is a need to continue research-related medical treatment on current

research Participants for their safety and well-being. The Researcher should provide as much detail as possible about the proposed continued activities. The REB Chair or Designee will review the request as quickly as possible and discuss the proposed continued activities with the Researcher;

5.4.3 The Researcher must document the reasons for the lapse and identify the steps taken to prevent future lapses;

5.4.4 If the REB approval lapses and the Researcher wants to continue with the research, the REB will complete the review of the research as soon as possible and the Researcher may resume the suspended activities once approval of the research has been issued. The lapse in approval will be documented.

6.0 REFERENCES

See References.

7.0 REVISION HISTORY

SOP Code	Effective Date	Summary of Changes
SOP405.001	15-Sept-2014	Original version
SOP405.002	08-Mar-2016	No revisions needed
SOP405.003	08-Oct-2019	No revisions needed
SOP405.004	15-May-2023	No revisions needed
SOP405.005	14-Apr-2026	2.0: changed ‘guidelines’ to ‘policies’; 5.2.3: deleted ‘including verification of the currently approved informed consent forms’ after the word ‘completeness’.

SOP 406.005

Title	Research Completion
SOP Code	406.005
Effective Date	14-Apr-2026

Site Approvals

Name and Title (typed or printed)	Signature	Date dd/Mon/yyyy

1.0 PURPOSE

This standard operating procedure (SOP) describes the procedures for the closure of research with the Research Ethics Board (REB).

2.0 SCOPE

This SOP pertains to REBs that review human Participant research in compliance with applicable regulations and policies.

3.0 RESPONSIBILITIES

All REB members and REB Office Personnel are responsible for ensuring that the requirements of this SOP are met.

The REB Chair or Designee is responsible for determining if any of the submitted materials should be reviewed by the Full Board.

4.0 DEFINITIONS

See Glossary of Terms.

5.0 PROCEDURE

The Completion of research is a change in activity that must be reported to the REB.

Although research Participants may no longer be at risk under the research, a final report allows the REB to close its files in addition to providing the REB with information that may be used in the evaluation and approval of related studies.

5.1 Determining when Research can be Closed

5.1.1 The Researcher may submit a research closure report to the REB once all Participant involvement and communication have ended, and no further data collection, follow-up, or interaction is expected. At that point, the project typically no longer poses ongoing ethical considerations related to Participant welfare or consent. however, Researchers and the REB should consider that some protocols remain open even after active participation concludes—particularly when identifiable or sensitive data are still being stored, analyzed, or used for future submissions. Keeping the protocol open in these cases ensures that any future data use is reviewed, Participant privacy is maintained, and the research team continues to meet applicable regulations and institutional requirements for safeguarding sensitive information.

5.1.2 The responsible REB Office Personnel will review the research closure application and request any outstanding information, clarification, or documentation from the Researcher, if needed;

5.1.3 The REB Chair or Designee will review the submission and issue a Letter of Acknowledgement to the Researcher. The research state will change to "*Closed*";

5.1.4 Once a research project is "*Closed*" with the REB, no further submissions for that research will be permitted; however, if required, the Researcher still may submit relevant documents for acknowledgement and, if applicable, further investigation and/or action may be undertaken by the REB;

5.1.5 If the Sponsor requests additional data following the closure of the research, a request for approval shall be made to the REB and the conditions of this request will be determined at the time of the review.

6.0 REFERENCES

See References.

7.0 REVISION HISTORY

SOP Code	Effective Date	Summary of Changes
SOP406.001	15-Sept-2014	Original version
SOP406.002	08-Mar-2016	No revisions needed
SOP406.003	08-Oct-2019	No revisions needed
SOP406.004	15-May-2023	No revisions needed
SOP 406.005	14-Apr-2026	2.0: replaced ‘guidelines’ with ‘policies’; 5.1.1: deleted ‘The Researcher may submit a research closure report to the REB when there is no further participant involvement at the site, all new data collection is complete, and the sponsor closeout activities, if applicable, have been completed. REB approvals are not expected to remain open until results are shared.’ Replaced with the new content of 5.1.1.

Title	Suspension or Termination of REB Approval
SOP Code	407.005
Effective Date	14-Apr-2026

Site Approvals

Name and Title (typed or printed)	Signature	Date dd/Mon/yyyy

1.0 PURPOSE

This standard operating procedure (SOP) describes the procedures associated with the suspension or termination of the Research Ethics Board's (REB) approval of research (including the suspension or termination of approval).

2.0 SCOPE

This SOP pertains to REBs that review human Participant research in compliance with applicable regulations and policies.

3.0 RESPONSIBILITIES

All REB members and REB Office Personnel are responsible for ensuring that the requirements of this SOP are met.

The REB is responsible for determining whether any information received throughout the course of the research requires the suspension or termination of REB approval for the research being considered.

The Researcher is responsible for notifying the REB and the organization of any suspensions or terminations of the research by the Sponsor and for providing a detailed explanation for the action.

The REB Chair or Designee is not authorized to terminate REB approval; however, the REB Chair or Designee is authorized to suspend REB approval, which must be reported

to the REB at its next Full Board meeting. The REB is authorized to terminate REB approval following its review at a Full Board meeting.

The REB Chair or Designee shall notify the Researcher, and the Organizational Official(s), of any suspension or termination of REB approval towards the research and has the authority to notify the regulatory authorities (as applicable) and the Sponsor. The REB may delegate regulatory authority reporting to the organization.

4.0 DEFINITIONS

See Glossary of Terms.

5.0 PROCEDURE

As a result of ongoing review activities, the REB may require that research be modified, or may suspend or terminate REB approval if the risks to the research Participants are determined to be unreasonably high; for example, cases in which there are high numbers of unexpected serious adverse events, or when there is evidence that the Researcher is not conducting the research in compliance with applicable regulations and policies. The REB also has the authority to suspend new enrollment while additional information is requested.

A decision to suspend or to terminate the REB's approval of the research must include consideration of the safety, rights, and well-being of the Participants already enrolled in the research; specifically, how to continue the care of enrolled Participants, and how and when the notification to Participants of the suspension or termination of the research will take place.

Any requests to lift a suspension or to re-approve the research must be reviewed by the Full Board.

A Researcher may decide to voluntarily suspend or terminate some or all research activities; however, this is not considered a suspension or termination of REB approval.

5.1 Suspension or Terminations of Research by the Sponsor

5.1.1 The Sponsor of the research may suspend or terminate the research (e.g., following results of interim analyses, due to inadequate drug availability, in response to a Data and Safety Monitoring Board (DSMB) recommendation, due to pre-planned stopping criteria, etc.);

5.1.2 The Researcher must immediately notify the REB of any suspensions or terminations of the research and the reasons for the action;

5.1.3 Reports of suspensions or terminations of the research by the Sponsor will be forwarded to the REB Chair or Designee for review;

5.1.4 If the REB Chair or Designee decides to suspend REB approval of the research, they must notify the REB at its next Full Board meeting;

5.1.5 If REB approval is suspended, a subsequent review must be conducted, and the REB suspension must be lifted prior to resumption of the research following the Sponsor's lifting of a suspension.

5.2 Suspension or Termination of REB Approval

5.2.1 If any concerns are raised during the REB's oversight of the research that are related to new information or to the conduct of the research, the REB may suspend or terminate its approval of the research as appropriate. These concerns may include:

- The research not being conducted in accordance with the REB-approved protocol or REB requirements,
- The research is associated with unexpected serious harm to Participants (i.e., as may be determined following REB review of reportable events or DSMB reports),
- Falsification of research records or data,
- Failure to comply with prior conditions imposed by the REB (i.e., under a suspension or approval with modifications),
- Repeated or deliberate failure to properly obtain or document consent from research Participants,
- Repeated or deliberate failure to limit administration of the investigational drug or device to those research Participants under the Researcher's supervision,
- Repeated or deliberate failure to comply with conditions placed on the research by the REB, by the Sponsor, or by regulatory agencies,
- Repeated or deliberate failure to obtain prior REB review and approval of amendments or modifications to the research, or
- Repeated or deliberate failure to maintain accurate research records or submit required reportable event reports to the REB;

5.2.2 The REB Chair or Designee is authorized to suspend REB approval of research. If the Chair or Designee suspends approval of the research, they must notify the REB as per applicable requirements;

5.2.3 The REB is authorized to terminate its approval of the research following a review at a Full Board meeting;

5.2.4 Prior to suspending or terminating REB approval, the REB must consider:

- Risks to current Participants,
- Actions to protect the safety, rights, and well-being of currently enrolled Participants,
- The appropriate care and monitoring of research Participants,
- Whether withdrawal of enrolled Participants is warranted and the specific procedures for their safe withdrawal,
- Whether Participants should be informed of the termination or suspension,
- Whether adverse events or outcomes should be reported to the REB,
- Identification of a time frame in which the corrective measures are to be implemented;

5.2.5 The REB Chair or Designee will notify the Researcher of any suspensions or terminations of REB approval, and the reasons for the decision;

5.2.6 Unless otherwise stated by the REB, when the REB Chair or Designee suspends or terminates ethics approval of the research, no further activities can take place other than the submission of an amendment or reportable events;

5.2.7 If the research is suspended or terminated, the REB Chair or Designee will issue a formal letter to the Researcher with the reason(s) for the REB action and the corrective measures proposed by the REB;

5.2.8 If REB approval has been suspended, the suspension may be lifted after corrective actions are completed to the REB's satisfaction.

5.3 Reporting Suspensions or Terminations

The REB Chair or Designee will report any suspension or termination of REB approval to the appropriate Organizational Official(s) and has the authority to notify the regulatory authorities (as applicable), and the Sponsor. The REB may delegate regulatory authority reporting to the organization.

6.0 REFERENCES

See References.

7.0 REVISION HISTORY

SOP Code	Effective Date	Summary of Changes
SOP407.001	15-Sept-2014	Original version
SOP407.002	08-Mar-2016	5.1.5: revised to remove requirement for Full Board review; 5.2.2: revised to remove the requirement to report suspension of approval by the REB Chair/designee at the next Full Board Meeting.
SOP407.003	08-Oct-2019	No revisions required
SOP407.004	15-May-2023	No revisions required
SOP407.005	14-Apr-2026	2.0 and 5.0: replaced ‘guidelines’ with ‘policies’; 5.2.8: edited ‘If REB approval of a research or if the conduct of the research has been suspended, the suspension may be lifted after corrective actions are completed to the REB’s satisfaction’ to remove “of a research or the conduct of the research”.

N2 NETWORK OF NETWORKS RÉSEAU DES RÉSEAUX

CAREB ACCER

SOP 501.005

Title	REB Review During Publicly Declared Emergencies
SOP Code	501.005
Effective Date	14-Apr-2026

Site Approvals

Name and Title (typed or printed)	Signature	Date dd/Mon/yyyy

1.0 PURPOSE

This standard operating procedure (SOP) describes the research ethics review procedures during a publicly declared emergency.

2.0 SCOPE

This SOP pertains to Research Ethics Boards (REB) that review human Participant research in compliance with applicable regulations and policies.

3.0 RESPONSIBILITIES

All REB members and REB Office Personnel are responsible for ensuring that the requirements of this SOP are met.

4.0 DEFINITIONS

See Glossary of Terms.

5.0 PROCEDURE

A publicly declared emergency is an emergency situation that, due to the extraordinary risks it presents, has been proclaimed as such by an authorized public official in accordance with legislation and/or public policy. Publicly declared emergencies arise

suddenly or unexpectedly and require urgent or quick responses. Examples include natural disasters, large communicable disease outbreaks, environmental disasters, and humanitarian emergencies. Such emergencies may represent significant risks for research Participants in ongoing research or in new research initiated as a result of the emergency. Potential research Participants who may not normally be considered vulnerable may become so by the very nature of the public emergencies, while those already vulnerable may become acutely so.

During publicly declared emergencies, the REB must have established procedures to continue to provide the necessary research ethics oversight. Research ethics review during publicly declared emergencies may necessitate the use of innovative practices. Depending upon the nature of the emergency, for example, REBs might not be able to meet in person, and Delegated review procedures may have to be designed to respond to either urgent opportunities for new research or current ongoing research. The existence of an emergency does not override established procedures to protect the welfare of research Participants. Any relaxation of the usual procedural requirements for review should be proportionate to the complexity and urgency of the emergency, as well as to the risks posed by the research under review. Any modifications that are made in the application of research ethics policies and procedures during a publicly declared emergency must be documented and appropriately justified.

5.1 Determining the Level of Impact

5.1.1 Subsequent to an officially publicly declared emergency, the REB Chair or Designee will assess the level of impact on the research ethics review processes;

5.1.2 There are three levels of impact that may influence how ethics review will be conducted during the publicly declared emergency:

- **Mild** – little or no impact,
- **Moderate** – some impact; decisions to proceed at the discretion of the Chair or Designee, in consultation with the Researcher, as necessary,
- **Severe** – extremely debilitating to normal research ethics review procedures;

5.1.3 The REB Chair or Designee will use the level of impact to guide the review of research submissions during the publicly declared emergency;

5.1.4 Pending the determination of the level of impact on the review of ongoing or new research, the currently established ethics review procedures should be followed.

5.2 Emergency Preparedness Procedures

5.2.1 Subsequent to an officially publicly declared emergency, temporary ethics review processes may be instituted;

5.2.2 The REB Chair or Designee may suspend the currently established REB meeting quorum, in which case an REB subcommittee would be established for the duration of the publicly declared emergency;

5.2.3 The REB subcommittee composition should be in accordance with the standard REB membership requirements and should include at least five members drawn from the existing REB membership;

5.2.4 The current REB Chair or Designee should serve as the Chair of the REB subcommittee;

5.2.5 At their discretion, the REB subcommittee Chair or Designee may invite individuals with expertise in special areas to assist in the review of issues that require expertise beyond that available to the REB subcommittee; however, ad hoc advisors may not contribute directly to the subcommittee's decision and their presence shall not be used in establishing a quorum;

5.2.6 When the impact is deemed to be severe, the REB Chair or Designee may refer the ethics review and research oversight of new and ongoing research to another REB, subject to the applicable regulations and agreements;

5.2.7 Where research submissions are deemed to be more than minimal risk and subject to applicable regulations, the REB Chair or subcommittee Chair or Designee will use their judgment in determining the type of review required (Delegated or Full Board), taking into account the severity of the impact of the emergency and the complexity and urgency of the submission;

5.2.8 Any modifications that are made in the application of research ethics policies and procedures during a publicly declared emergency must be documented and appropriately justified;

5.2.9 The REB Chair or Designee should periodically assess the impact of the emergency on the ethics review processes and adjust any temporary ethics review processes accordingly;

5.2.10 Any modifications that are made in the application of research ethics policies and procedures during a publicly declared emergency will cease as soon as is feasible after the emergency has officially ended (i.e., as declared by an authorized public official). The REB Chair or Designee will determine when to resume routine ethics review processes;

5.2.11 All delegated approvals of research following a publicly declared emergency must be assessed to determine if subsequent Full Board review is required at the first opportunity subsequent to the cessation of the publicly declared emergency;

5.2.12 At the conclusion of the publicly declared emergency, the REB Chair or Designee and the REB Office Personnel should work with the REB subcommittee members to evaluate the effectiveness of its declared emergency procedures and to make recommendations for improvements.

5.3 Review of Ongoing Research NOT Related to or Arising from the Publicly Declared Emergency

5.3.1 When the impact of the publicly declared emergency on ethics review is determined to be mild to moderate, the following will apply to the review of ongoing research:

- The REB Chair or Designee will determine if the research needs to continue, or if it can be postponed until after the emergency is over,
- The research may continue at the discretion of the REB Chair or Designee in consultation with the Researcher, as necessary,
- Researcher's response to REB reviews, major amendments, and adverse events will be prioritized for review,
- Continuing reviews will receive the next priority for review, followed by research completion reports,
- Other submissions will be reviewed as time allows;

5.3.2 When the impact of the publicly declared emergency on ethics review is determined to be severe, the following will apply to the review of ongoing research:

- Research activities not involving, or no longer involving, recruitment or direct contact with Participants may continue,
- Research activities involving recruitment or direct contact with Participants may only continue if ceasing such activity might pose significant risks to Participant safety,
- Major amendments and adverse events related to these studies will be reviewed by the REB subcommittee or the REB subcommittee Chair or Designee, as appropriate;

5.3.3 At the REB Chair or Designee's discretion, and subject to applicable regulations, review procedures may be delayed or temporarily suspended depending upon volume. In such cases, research shall be deemed to have continued approval until such time that the REB is able to conduct its review.

5.4 Review of New Research NOT Related to or Arising from the Publicly Declared Emergency

5.4.1 When the impact of the publicly declared emergency on ethics review is determined to be mild to moderate, the REB Chair or Designee will determine whether review of any new research not related to the publicly declared emergency may proceed or will be postponed until after the emergency is over;

5.4.2 When the impact of the publicly declared emergency on ethics review processes is determined to be severe, any new research not related to the publicly declared emergency will not be reviewed until the emergency is declared to be over.

5.5 Review of Research RELATED to or Arising from the Publicly Declared Emergency

5.5.1 If a request to review research related to a publicly declared emergency is received, it will be directed to the REB Chair or REB subcommittee Chair or Designee, as applicable;

5.5.2 The REB Chair or Designee will assess the risks associated with the proposed research, as well as aspects of the research that might require enhanced scrutiny or diligence, taking into account the severity of the impact of the emergency on ethics review processes;

5.5.3 When the impact of the publicly declared emergency on ethics reviews is determined to be mild to moderate, research related to the publicly declared emergency has priority for review;

5.5.4 When the impact of the publicly declared emergency on ethics review is determined to be severe, time-sensitive review processes may be followed, such as Delegated review as appropriate, review by an REB subcommittee, and/or meetings conducted via teleconference or videoconference.

6.0 REFERENCES

See References.

7.0 REVISION HISTORY

SOP Code	Effective Date	Summary of Changes
SOP501.001	15-Sept-2014	Original version
SOP501.002	08-Mar-2016	No revisions needed
SOP501.003	08-Oct-2019	No revisions needed
SOP501.004	15-May-2023	5.2.7 and 5.2.9: replaced ‘his/her’ with ‘their’.

SOP Code	Effective Date	Summary of Changes
SOP501.005	14-Apr-2026	2.0: replaced ‘guidelines’ with ‘policies’. Deleted 5.2.2: ‘When the impact on the ethics review processes is deemed to be severe, teleconferences or videoconferences may be used to conduct meetings.’ Deleted 5.2.3: ‘When the impact on the ethics review processes is deemed to be severe, REB office personnel may conduct their activities remotely (via remote email and voice mail access) with minimal disruption of services.

Title	Communication – Researcher
SOP Code	601.005
Effective Date	14-Apr-2026

Site Approvals

Name and Title (typed or printed)	Signature	Date dd/Mon/yyyy

1.0 PURPOSE

This standard operating procedure (SOP) describes the Research Ethics Board's (REB) communication with the Researcher and with their research team.

2.0 SCOPE

This SOP pertains to REBs that review human Participant research in compliance with applicable regulations and policies.

3.0 RESPONSIBILITIES

All REB members and REB Office Personnel are responsible for ensuring that the requirements of this SOP are met.

4.0 DEFINITIONS

See Glossary of Terms.

5.0 PROCEDURE

In the interest of enhancing human research Participant protection, it is important for the REB to foster collaboration and open communication between and among the REB, Researcher, research staff, and organizational representatives. This applies not only to

communication related to a specific research project, but also to communication related to ethical issues and REB processes, policies, and procedures.

All Researchers participating in REB approved research shall be informed, in writing, of all determinations made by the REB regarding specific research.

Feedback from Researchers should be encouraged and should be considered as an opportunity to review and to improve the function of the REB and of the REB office procedures.

In order to facilitate clear and accurate communication with Researchers and research staff, the REB will follow standardized notification and documentation procedures.

5.1 Notification of REB Decisions

5.1.1 The REB will notify the Researcher and/or their research staff of the REB's decision in a timely manner, following the review (i.e., from the REB meeting or Delegated review date) of new research, amendments to currently approved research, applications for continuing review or reportable events;

5.1.2 The determinations of the REB will be summarized noting any concerns or requests for clarification including recommended changes to research-related documents, and clarifying the reasons for the disapproval of the submission (when appropriate);

5.1.3 If the research does not receive initial approval or is denied re-approval (for continuing review), the REB Chair or Designee will notify the Researcher of the REB's decision as soon as possible following the REB meeting. Formal written notification will follow;

5.1.4 The REB Chair or Designee will review the draft REB review letter, make revisions as necessary, and will indicate their approval;

5.1.5 The REB review letter will be issued to the Researcher(s);

5.1.6 The Researcher will be asked to include the REB number or equivalent designation assigned to the research in all subsequent correspondence with the REB;

5.1.7 Upon receipt of the Researcher response to the REB review letter, the REB will follow-up with the Researcher and/or their staff to request any additional clarifications as needed, or as requested by the REB Chair or Designee, or the Reviewers;

5.1.8 Once all of the REB conditions are satisfied, the REB will issue an approval letter.

5.2 Researcher Appeal of REB Decision

5.2.1 A Researcher may request a reconsideration or appeal the decision of the REB and/or any of the revisions to the research requested by the REB;

5.2.2 Appeals are conducted in accordance with established organizational policy at the applicable organization;

5.2.3 Only the REB may lift a restriction or re-review previously disapproved research. Delegated review procedures may not be used.

6.0 REFERENCES

See References.

7.0 REVISION HISTORY

SOP Code	Effective Date	Summary of Changes
SOP601.001	15-Sept-2014	Original version
SOP601.002	08-Mar-2016	No revisions needed
SOP601.003	08-Oct-2019	5.1.1: 'within a time frame specified by the REB' changed to 'in a timely manner.'
SOP601.004	15-May-2023	No revisions needed
SOP601.005	14-Apr-2026	1.0, 5.1.1, 5.1.4: replaced 'his/her' with 'their'; 2.0: replaced 'guidelines' with 'policies'; 5.1.1: deleted redundant term 'modifications'; 5.1.2: replaced 'the consent form' with 'study documents'.

SOP 602.005

Title	Communication – Research Participants
SOP Code	602.005
Effective Date	14-Apr-2026

Site Approvals

Name and Title (typed or printed)	Signature	Date dd/Mon/yyyy

1.0 PURPOSE

This standard operating procedure (SOP) describes the Research Ethics Board's (REB) communication with research Participants.

2.0 SCOPE

This SOP pertains to REBs that review human Participant research in compliance with applicable regulations and policies.

3.0 RESPONSIBILITIES

All REB members and REB Office Personnel are responsible for ensuring that the requirements of this SOP are met.

4.0 DEFINITIONS

See Glossary of Terms.

5.0 PROCEDURE

Research Participants should be able to voice their concerns, questions, and request information regarding their participation or potential participation in research, in confidence, to an informed individual on the REB or in the REB office.

5.1 Communication with Research Participants

5.1.1 Research Participants are encouraged to contact (by telephone or in writing) the REB office with questions and concerns, using the contact information provided in the informed consent document(s). The identity of the Participant will be shared with the REB Chair and with the organization's appropriate representative, if applicable, and if the Participant provides their consent;

5.1.2 The REB Office Personnel must document all communication with the research Participant;

5.1.3 The REB Office Personnel will communicate Participant concerns to the REB Chair or Designee;

5.1.4 The REB Chair or Designee works to resolve Participant issues which may include a follow-up with the Researcher or the Researcher's supervisor or other organizational representative, and with appropriate federal agencies, as applicable;

5.1.5 The REB Chair or Designee documents all communication with the research Participant, and a de-identified record of this communication is maintained securely and in the relevant research file.

6.0 REFERENCES

See References.

7.0 REVISION HISTORY

SOP Code	Effective Date	Summary of Changes
SOP602.001	15-Sept-2014	Original version
SOP602.002	08-Mar-2016	No revisions needed
SOP602.003	08-Oct-2019	5.1.1: revision of last sentence including deletion of, 'if requested' and 'will not be recorded,' new language bolded: '~~If requested~~ The identity of the participant will ~~not be recorded~~ **be** shared **with the REB chair and with the organization's appropriate representative if applicable, and if the participant provides their consent**'.

SOP Code	Effective Date	Summary of Changes
SOP602.004	15-May-2023	No revisions required
SOP602.005	14-Apr-2026	2.0: replaced ‘guidelines’ with ‘policies.

Title	Informed Consent Process
SOP Code	701.005
Effective Date	14-Apr-2026

Site Approvals

Name and Title (typed or printed)	Signature	Date dd/Mon/yyyy

1.0 PURPOSE

This standard operating procedure (SOP) describes the requirements for the informed consent form and the process for waiving or obtaining and documenting initial and ongoing informed consent.

2.0 SCOPE

This SOP pertains to REBs that review human Participant research in compliance with applicable regulations and policies.

3.0 RESPONSIBILITIES

All REB members and REB Office Personnel are responsible for ensuring that the requirements of this SOP are met.

The Researcher is responsible for providing the REB with a detailed description of the rationale for a consent waiver or the consent documents and a description of the consent process. The Researcher is also responsible for providing a description of the recruitment methods and recruitment materials (if applicable).

When a written informed consent form is used, the Researcher, the research Sponsor, and the REB are jointly responsible for ensuring that the consent form contains all of the basic elements of consent and the applicable additional elements of consent. The REB is responsible for verifying that the consent form (if applicable) contains the required elements.

The REB is responsible for determining whether informed consent exemptions or waivers are applicable and appropriate.

The REB Chair or Designee is responsible for reviewing consent forms or changes to consent forms if the changes meet the criteria for Delegated review.

4.0 DEFINITIONS

See Glossary of Terms.

5.0 PROCEDURE

5.1 REB Review of Required Elements of Informed Consent

5.1.1 The REB members will review the proposed consent process for appropriateness, and the proposed consent form(s) for general readability, for appropriateness of the language and content, and for the inclusion of the applicable elements per TCPS2 Chapter 3, the organization's guidelines and all applicable regulations;

5.1.2 The REB will review the proposed consent form to ensure that it contains adequate information to safeguard the privacy and confidentiality of research Participants;

5.1.3 The REB may require a separate consent form for optional procedures or sub-studies (e.g., tissue, blood, genetic testing or specimen banking);

5.1.4 Following the review, the REB may approve the consent form(s) as submitted or require changes;

5.1.5 When changes are required by the REB and are made by the Researcher, the REB Chair or Designee will review the consent form(s) to confirm that the required changes have been made and that the version date has been updated;

5.1.6 When the changes meet the criteria for Delegated review, the revised consent will be provided to the REB Chair or Designee for review and approval;

5.1.7 When changes do not meet the criteria for Delegated review, the revised consent form will be reviewed at the next Full Board meeting.

5.2 Translation of Informed Consent Documents

5.2.1 The informed consent document should be in the language understandable to the research Participant (or acceptable representative);

5.2.2 When a research Participant is non-English or French speaking, documentation of informed consent can be by one of two methods:

- **Written consent**: The REB approved English/French version of the informed consent document is translated into the research Participant's native language. The REB may require that translated informed consents be accompanied by an attestation from a translator certifying that the translated informed consent accurately reflects the REB approved English informed consent. This method is preferred if it is anticipated that a significant percentage of a prospective research population is non-English speaking. A translated informed consent document does not replace the need for an interpreter to be present during the consent process and throughout the research. The research Participant will sign the translated version of the informed consent form document,
- **Oral consent**: If applicable/acceptable, a qualified interpreter fluent in both English/French and the research Participant's native language orally interprets the REB approved English/French consent form to the research Participant. The interpreter should be an impartial person. When the person obtaining consent is assisted by an interpreter, the interpreter must sign and date the consent form;

5.2.3 If a research Participant is unable to read, an impartial witness must be present during the entire informed consent discussion. Verbal consent is obtained from the research Participant after the informed consent document, and any other written information is read and explained to the research Participant. Signatures will be obtained from the research Participant (if capable) and the impartial witness on the informed consent document, where applicable. The signature of the impartial witness attests that the information was accurately explained to, and apparently understood by, the research Participant, and that informed consent was freely given by the research Participant;

5.2.4 The REB requires that the translated informed consent materials be submitted for review and approval prior to use in enrolling non-English/French-speaking Participants. The REB may require that the Researcher include a certificate or statement signed by the translator indicating that the translated materials are a true and accurate translation of the REB approved English materials;

5.2.5 The REB may follow Delegated review procedures to review and approve translated informed consent materials if the English language materials have already been approved (particularly if a signed translation certificate or statement is on file);

5.2.6 An interpreter should be available to the research Participant throughout the research;

5.2.7 The interpreter must sign and date the consent form attesting that the research was accurately explained to, and appeared to be understood by, the research Participant.

5.3 Consent Update for Ongoing and Completed Research Participants

5.3.1 The Researcher must inform research Participants of any new information that might affect their willingness to continue their participation in the research or that may affect their long term health even if they have completed their participation in the research, including those who have withdrawn or been removed from the study;

5.3.2 The Researcher must obtain the currently enrolled Participant's consent to continue to participate if there is a significant change to the research or risk;

5.3.3 If required, written documentation of ongoing consent for currently enrolled Participants may be obtained by having the research Participant sign an REB approved consent document containing the updated information;

5.3.4 If applicable, ongoing consent may be obtained orally by contacting the research Participant by phone, providing the updated information, and documenting their agreement to continue;

5.3.5 The nature of the provision of the new information to currently enrolled Participants and the documentation required will be determined by the REB;

5.3.6 The Researcher must inform former research Participants of any new information that may be relevant to their long-term health by contacting them via phone or mail or in person, as applicable.

5.4 Recruitment Methods

5.4.1 **Researcher's Patients:** If the patient is under the care of the Researcher, the Researcher may approach the patient directly, but in such a manner that the patient does not feel pressured or obligated in any way. In this instance, the patient's consent should be obtained by an individual other than the Researcher. Any exceptions to this procedure must be appropriately justified and submitted to the REB for review;

5.4.2 **In circumstances where the Researchers will obtain consent:** The Researcher must ensure that the consent has been obtained without undue coercion or influence and that there is no likelihood of therapeutic misconception, if applicable;

5.4.3 **Referrals:** The Researcher may send a letter to colleagues asking for referrals of potential patients. The Researcher may provide colleagues with an REB approved consent form or research information sheet to give to their patients. The patient will then be asked to contact the Researcher directly, or, with documented permission from the patient, the Researcher may initiate the call;

5.4.4 **Health Records Department:** The Researcher may ask the Health Records Department to identify patients who appear to meet the research's eligibility criteria. The Researcher should supply Health Records with a standard letter describing the research to give the patient's physician and ask whether the physician would be willing to approach their patients about participation. It is NOT acceptable for the Researcher or their staff to contact patients identified through hospital records, clinic charts or other databases independently by phone, unless the patient has previously agreed, or is already under the medical care of the Researcher;

5.4.5 **Registries:** If the REB has previously approved a patient research registry and the patient has provided permission to be contacted for potential research, the Researcher or their research team may contact these patients directly. The person contacting the patient should identify themselves as associated with the patient's clinical caregiver, and remind the patient that they have agreed to be contacted. The patient must be offered the option of having their name removed from the database;

5.4.6 **Advertising:** The REB must first review and approve the text and the use of any advertisements, notices, or media messages.

5.5 Recruitment Materials

5.5.1 The REB reviews the recruitment materials (e.g., advertisements, letters, notices) for evidence of coercion or undue influence and consistency with the REB approved research and informed consent document;

5.5.2 All recruitment materials must be approved by the REB and by each organization where the recruitment material will be displayed, as per local practice prior to their use.

5.6 Documentation of Informed Consent

5.6.1 The REB typically requires documentation of informed consent by the use of a written informed consent form approved by the REB,which has been signed and dated by the research Participant or the research Participant's Authorized third party, and by the person obtaining consent;

5.6.2 As required by the Research Sponsor or if required by organizational policies, the person who obtains consent must also sign and date the informed consent form for clinical trials;

5.6.3 A copy of the signed and dated consent form shall be provided to the research Participant;

5.6.4 The Researcher or Designee may document details of the consent process in the research Participant's medical record, according to the organization's guidelines;

5.6.5 The Researcher should inform the research Participant's primary health care provider about the research Participant's involvement in the research if the research Participant agrees to the primary health care provider being informed;

5.6.6 The REB may approve a short form written consent document in cases where the research Participant may lack the capacity to consent. The short form consent form contains all required elements of informed consent. A written summary of the information is presented orally to the research Participant or their Authorized third party. The short form consent document is signed by the research Participant or the substitute decision maker. An impartial witness must be present during the oral presentation. The witness must sign both the short form consent document and a copy of the written summary. The person obtaining consent must sign a copy of the written summary of the information that is presented orally;

5.6.7 The REB may approve a process that allows the informed consent document to

be delivered by regular mail, email, or other institutionally approved methods of document transfer to the potential Participant, and to conduct a consent interview by telephone or videoconference when the Participant can read the consent document as it is discussed. All other applicable conditions for documentation of informed consent must also be met when using this procedure;

5.6.8 In some types of research, and for some groups or individuals where written signed consent may be culturally inappropriate, the REB may approve the process of oral consent, a verbal agreement or a handshake;

5.6.9 Where consent is not documented in a signed consent form, Researchers may use a range of consent procedures (e.g., oral consent, field notes, implied consent through the return of a completed questionnaire). The procedures used to seek consent must be documented by the Researcher and approved by the REB;

5.6.10 Whenever possible, the research Participant should have written documentation of participation in a research project unless it may compromise their safety or confidentiality.

5.7 Consent Monitoring

5.7.1 In considering the adequacy of informed consent procedures, the REB may require monitoring of the consent process by an impartial observer;

5.7.2 Such monitoring may be particularly warranted when the research presents significant risks to Participants, or if Participants are likely to have difficulty understanding the information to be provided;

5.7.3 Monitoring may also be appropriate as a corrective action when the REB has identified problems associated with a particular Researcher or a research project.

5.8 Waiver or Alteration of Informed Consent

5.8.1 The REB may approve a consent procedure that does not include, or which alters, some or all of the elements of informed consent, or waive the requirements to obtain informed consent, provided that the REB finds and documents that:

- The regulatory and ethics policy framework supports the waiver,
- The research involves no more than minimal risk to the Participants,
- The waiver or alteration is unlikely to adversely affect the rights and welfare of the Participants,

- The research could not practicably be carried out without the waiver or alteration,
- The precise nature and extent of any proposed alteration is defined,
- The information is used in a matter that will ensure its confidentiality,
- Whenever appropriate, the Participants will be provided with additional pertinent information after participation;

5.8.2 Debriefing should be a part of all research involving an alteration to consent requirements whenever it is possible, practicable, and appropriate;

5.8.3 Participants should have the opportunity to refuse consent and request the withdrawal of their data and/or specimens whenever possible, practicable, and appropriate;

5.8.4 If there are limitations to withdrawing consent, these must be disclosed to the Participant prior to obtaining their consent.

5.8.5 These findings and their justifications shall be clearly documented in the REB minutes when the REB exercises this waiver provision;

5.8.6 Researchers are not required to seek Participant consent for secondary use of non-identifiable information or non-identifiable biological specimens.

5.9 Consent for Research Involving Individuals Who Lack Capacity

5.9.1 For research involving individuals who lack capacity, either permanently or temporarily, to decide for themselves whether to participate, the REB must ensure that at a minimum the following conditions are met:

- The Researcher involves Participants who lack the capacity to consent on their own behalf to the greatest extent possible in the decision-making process,
- The Researcher seeks and maintains consent from Authorized third parties,
- The Authorized third party is not the Researcher or any other member of the research team,
- The Researcher demonstrates that the research is being carried out for the Participant's direct benefit or for the benefit of other persons in the same category. If the research does not have the potential for direct benefit to the Participant, the Researcher shall demonstrate how the research will expose the Participant to only a minimal risk and how the Participant's welfare will be protected during participation in the research;

5.9.2 If an Authorized third party has consented on behalf of a person who lacks legal capacity, but that person has some ability to understand the significance of the research, the Researcher ascertains the wishes of that individual with respect to participation;

5.9.3 Assent from a Participant is not sufficient to permit them to participate in a research project in the absence of consent by an Authorized third party; however, their expression of dissent is respected;

5.9.4 Prospective Participants who may be capable of verbally or physically assenting to, or dissenting from, participation in research include:

- Those whose capacity is in the process of development, such as children whose capacity for judgment and self-direction is maturing,
- Those who were once capable for making an autonomous decision regarding consent, but whose capacity is diminishing or fluctuating, and
- Those whose capacity remains only partially developed, such as those living with permanent cognitive impairment;

5.9.5 If assent for research is required, the Researcher must submit to the REB the proposed procedures for obtaining consent from the capable substitute decision maker and assent from the research Participant. The Researcher must submit an assent form or summary of the assent process to the REB for approval as per the organization's guidelines;

5.9.6 When authorization for participation was granted by an Authorized third party, and the Participant acquires or regains capacity during the research, the Researcher will seek the Participant's consent as a condition of continuing participation;

5.9.7 If an individual signed a research directive indicating their preference for ongoing and/or future participation in research, in the event that the individual loses capacity or upon their death, an Authorized third party may be guided by these directives during the consent process.

5.10 Other Individuals and Groups who may be Vulnerable in the Context of Research

5.10.1 The REB will determine appropriate protections for individuals and groups who might be inappropriately excluded from research on the basis of attributes such as culture, language, sex, race, ethnicity, age, and disability, and who require additional protections. For these individuals and groups, the REB will take into account the risks and benefits of the research, and will consider protections

afforded by organizational policies, and provincial and federal law.

Other individuals or groups whose circumstances may make them vulnerable in the context of research should not be inappropriately included or automatically excluded from participation in research on the basis of their circumstances;

5.10.2 In addition, when the REB regularly reviews research involving individuals, groups or populations who may be vulnerable in the context of research, consideration shall be given to the inclusion of one or more individuals who are knowledgeable and experienced in working with these Participants.

Participants may include, but are not limited to:

- Children,
- The Elderly,
- Individuals with mental illness,
- Pregnant women,
- Individuals with limited language skills,
- Indigenous individuals and communities,
- Prisoners;

5.10.3 If research involves prisoners, children, pregnant women, fetuses, and/or neonates, and is funded or supported by the US Federal Government, the REB shall apply the requirements of 45 CFR 46, including as appropriate, Sub-Parts, B, C and D.

5.11 Consent for Research in Health Emergencies

5.11.1 The REB establishes the criteria for the conduct of research involving medical emergencies prior to approval of the research. The Researcher must justify to the REB the reasons why an exception to obtaining informed consent from Participants is required;

5.11.2 The REB allows research that involves health emergencies to be carried out without the free and informed consent of the Participant or of their Authorized third party if ALL of the following apply:

- A serious threat to the prospective Participant requires immediate intervention,
- Either no standard efficacious care exists, or the research offers a real possibility of direct benefit to the Participant in comparison with standard care,
- Either the risk of harm is not greater than that involved in standard therapeutic care, or it is clearly justified by the potential for direct benefit to the Participant,

- The prospective Participant is unconscious or lacks capacity to understand risks, methods, and purposes of the research project,
- Third-party authorization cannot be secured in sufficient time, despite diligent, and documented efforts to do so, and
- No relevant prior directive by the Participant is known to exist;

5.11.3 When a previously incapacitated Participant regains capacity, or when an Authorized third party is found, free and informed consent is sought for continuation in the project and for subsequent research-related procedures.

5.12 Consent and Secondary Use of Identifiable Information and/or Human Biological Materials for Research Purposes

5.12.1 The REB allows the secondary use of identifiable information and/or human biological materials for research purposes without obtaining consent from research Participants if the Researcher is able to satisfy the following conditions:

- Identifiable information/materials are essential to the research,
- The use of identifiable information/materials without the Participant's consent is unlikely to adversely affect the welfare of individuals to whom the information relates,
- The Researchers will take appropriate measure to protect the privacy of individuals, and to safeguard the identifiable information/materials,
- The Researchers will comply with any known preferences previously expressed by individuals about any use of their information/materials,
- It is impossible or impracticable to seek consent from individuals to whom the information relates/materials were collected, and
- The Researchers have obtained any other necessary permission for secondary use of information/materials for research purposes;

5.12.2 In cases where the secondary use of identifiable information/materials without the requirement to seek consent has been approved by the REB, if the Researcher proposes to contact individuals for additional information and/or materials, REB approval must be obtained prior to contact.

5.13 Incidental Findings

5.13.1 Within the limits of consent provided by the Participant, researchers shall disclose any material incidental findings discovered in the course of the research. The Researcher's plan to identify and to disclose incidental findings must be submitted to the REB and approved prior to implementation.

6.0 REFERENCES

See References.

7.0 REVISION HISTORY

SOP Code	Effective Date	Summary of Changes
SOP701.001	15-Sept-2014	Original version
SOP701.002	08-Mar-2016	No revisions needed
SOP 701.002_1	08-Mar-2017	5.8.1: removal of the criteria for a waiver that excludes a study with a therapeutic intervention; addition of 'The precise nature and extent of any proposed alteration is defined,' 5.8.2: addition of 'Debriefing should be a part of all research involving an alteration to consent requirements whenever it is possible, practicable and appropriate'; 5.8.3: addition of 'Participants should have the opportunity to refuse consent and request the withdrawal of their data and/or specimens whenever possible, practicable and appropriate'; 5.8.5: addition of 'Researchers are not required to seek participant consent for secondary use of non-identifiable information or non-identifiable biological specimens.'
SOP 701.003	08-Oct-2019	5.3.1: addition of, 'including those who have withdrawn or been removed from the study'; 5.10: revised Title to state '**Individuals and Groups who may be Vulnerable in the Context of Research;** 5.10: 5.10.1; 5.10.2 revised language for consistency with TCPS2 updated definition of vulnerable participants - i.e., vulnerable in the context of the research; 5.10.1: addition of, 'Other individuals or groups whose circumstances may make them vulnerable in the context of research should not be inappropriately included or automatically excluded from participation in research on the basis of their circumstances'; 5.10.2: revision of ' involving a vulnerable population'

SOP Code	Effective Date	Summary of Changes
		to 'involving individuals, groups or populations who may be vulnerable in the context of research'; deletion of ' Potentially vulnerable groups' in heading and change to 'Participants'; bullet #6: change to Indigenous from Aboriginal; 5.13.1: revision from, 'Researchers have an obligation to disclose to the participant any material incidental findings discovered in the course of research.' to, 'Within the limits of consent provided by the participant researchers shall disclose any material incidental findings discovered in the course of research.'
SOP 701.004	15-May-2023	5.2.2: addition of French 5.6.3 addition of "and dated" as per GCP 4.8.11? "*Prior to participation in the trial, the subject or the subject's legally acceptable representative should receive a copy of the signed and dated written informed consent form and any other written information provided to the subjects*"
SOP 701.005	14-Apr-2026	Title change from 'Informed Consent Form Requirements and Documentation' to better reflect this SOP's scope; 2.0, 5.8.1: replaced 'guidelines' with 'policies. 5.1.1: added 'per TCPS2 Chapter 3' 5.4.4, 5.4.5, and 5.11.2: replaced 'his/her' with 'their'. 5.5.2: deleted 'Advertisements should be reviewed by the REB, as applicable, and according to REB requirements.' as it is expected advertisements are covered under the next item, recruitment materials. Previous item 5.5.3 renumbered to 5.5.2. 5.6.1, 5.6.6: changed 'legally authorized representative to the Glossary term 'Authorized third party'. 5.6.2: changed 'Researcher' to 'the person who obtains consent' 5.6.4: changed 'should' to 'may'. 5.6.5: changed 'physician' to 'health care provider'. 5.6.7: replaced 'facsimile' with 'or other institutionally approved methods of document transfer'. 5.6.8: replaced 'felt by the participants as mistrust on

SOP Code	Effective Date	Summary of Changes
		the part of the Researcher' with 'culturally inappropriate'. 5.8.4: new, "If there are limitations to withdrawing consent, these must be disclosed to the participant prior to obtaining their consent. Previous items 5.8.4 and 5.8.5 renumbered accordingly.

Title	Researcher Qualifications and Responsibilities
SOP Code	801.005
Effective Date	14-Apr-2026

Site Approvals

Name and Title (typed or printed)	Signature	Date dd/Mon/yyyy

1.0 PURPOSE

This standard operating procedure (SOP) describes the qualifications and responsibilities of the Researcher who engages in research involving human Participants.

2.0 SCOPE

This SOP pertains to Research Ethics Boards (REB) that review human Participant research in compliance with applicable regulations and policies.

3.0 RESPONSIBILITIES

All Researchers, REB members, and REB Office Personnel are responsible for ensuring that the requirements of this SOP are met.

4.0 DEFINITIONS

See Glossary of Terms.

5.0 PROCEDURE

Research involving human Participants must be conducted by individuals appropriately qualified by education, training, and experience to assume responsibility for the proper conduct of the research and for the protection of human research Participants. The REB

must have assurance that the qualifications of new Researchers, for the conduct of research, are appropriate.

Researchers are required to conduct the research in compliance with applicable regulations and guidelines, and to comply with all REB policies.

5.1 Researcher Qualifications

5.1.1 The Researcher must make available to the REB or institution, as applicable,their current CV and medical license number (if applicable) and their relevant training and experience, in sufficient detail for the REB or institution to make an objective judgment regarding the Researcher's qualifications, if necessary;

5.1.2 If applicable, the Researcher must be a physician with a specialty qualification in their field and with current professional qualifications entitling them to provide health care under the applicable laws;

5.1.3 The Researcher must have completed appropriate training regarding the requirements of conducting and overseeing research;

5.1.4 If applicable, all specified Organizational Officials must approve the application to the REB;

5.1.5 The organizational approver's signature attests that:

- They are aware of the proposal and supports its submission for REB review,
- The application is considered to be feasible and appropriate,
- Any internal requirements have been met,
- The Researcher is qualified and has the experience and expertise to conduct this research,
- The Researcher has sufficient space and resources to conduct this research;

5.1.6 Any concerns raised in the REB review of the Researcher's qualifications will be communicated to the Researcher and must be satisfied prior to REB approval of the application.

5.2 Researcher Responsibilities

5.2.1 The Researcher is responsible for complying with the decisions and responsibilities set out by the REB. In addition, it is the Researcher's responsibility to comply with all applicable regulations and ensure that (if applicable):

- They and their staff members are appropriately qualified by education, training, and experience, per institutional requirements, to assume responsibility for the proper conduct of the research and for protection of human research Participants,
- They have adequate resources to properly conduct the research in accordance with the protocol and written SOPs, as applicable,
- All real, potential, or perceived conflicts of interest are declared to the REB at the time of the initial application, and as they arise,
- The REB review and approval is obtained before engaging in research involving human Participants,
- All necessary documentation is signed by the responsible Researcher, as applicable,
- Informed consent, when required, is obtained from Participants in accordance with applicable regulations prior to their enrollment into the research, and using the most current informed consent document(s) approved by the REB (as applicable),
- They personally conduct or supervise the described investigation(s),
- The research is conducted in compliance with the approved research and applicable reporting criteria are reported to the REB, including deviations, Serious, Unexpected Adverse Events, and Privacy Breaches,
- Any changes in the approved research are not initiated without REB review and approval, except where necessary to eliminate an immediate hazard(s) to the Participant(s),
- Premature termination or suspension of the research is reported to the REB;
- Accurate and complete records are maintained according to applicable regulatory requirements,
- Written summaries of the research status are submitted to the REB at least annually, or more frequently if required by the REB, and an application for continuing review is submitted to the REB prior to the expiration of REB approval,
- Any other unexpected finding or new research knowledge that could affect the risk/benefit ratio of the research is reported to the REB,
- The REB is notified if there is a change in Researcher,
- The REB is notified immediately if their medical or dental license or hospital privileges are suspended, restricted or revoked (if applicable), or should their qualifications otherwise no longer be appropriate,
- The REB is notified when the research is complete;

Note: (if applicable) the obligations of a Researcher holding a Clinical Trial Application (CTA) with Health Canada (i.e., Sponsor-Researcher) include both those of a Sponsor and those of a Researcher.

6.0 REFERENCES

See References.

7.0 REVISION HISTORY

SOP Code	Effective Date	Summary of Changes
SOP801.001	15-Sept-2014	Original version
SOP801.002	08-Mar-2016	No revisions needed
SOP801.003	08-Oct-2019	No revisions needed
SOP801.004	15-May-2023	Replaced his/her with their
SOP801.005	14-Apr-2026	2.0: replaced ‘guidelines’ with ‘policies’; 5.1.1: clarified the institution is responsible for verifying researcher qualifications. 5.1.5 and 5.2.1: replaced ‘he/she’ with ‘they’; 5.2.1: clarified researcher and institutional responsibility to verify qualifications of study team; added ‘the protocol’ to the second bullet point; 5.2.2: merged with 5.1.1 and deleted remaining (redundant) text.

Title	Quality Assurance Inspections
SOP Code	901.005
Effective Date	14-Apr-2026

Site Approvals

Name and Title (typed or printed)	Signature	Date dd/Mon/yyyy

1.0 PURPOSE

This standard operating procedure (SOP) describes the processes for monitoring, evaluating, and improving the effectiveness of the human research protection enterprise.

2.0 SCOPE

This SOP pertains to Research Ethics Boards (REB) that review human Participant research in compliance with applicable regulations and policies.

3.0 RESPONSIBILITIES

All REB members, REB Office Personnel, and the Quality Assurance Officer, if separate from the REB Office Personnel, are responsible for ensuring that the requirements of this SOP are met.

4.0 DEFINITIONS

See Glossary of Terms.

5.0 PROCEDURE

Quality Management programs, Quality Assurance (QA), and Quality Control (QC) activities, such as inspections of the REB and of Researchers, allow for continuous

evaluation and subsequent assurance of the human research protection enterprise. Findings are measured against established policies and procedures, and all of the applicable ethical, legal, and regulatory requirements. When areas for improvement are identified, corrective action is taken including training, education, and the revision of SOPs.

5.1 REB Quality Assurance Inspections (Internal)

5.1.1 The QA Officer will develop a schedule for routine QA inspections or initiate ad hoc inspections in response to complaints or other concerns;

5.1.2 QA inspections may include the REB and the REB office;

5.1.3 When the QA Officer conducts a QA inspection of the REB and the REB office the inspection may include the following:

- An assessment of the SOPs and compliance with applicable regulations and guidance,
- A review of research files, REB membership rosters, REB attendance records, and REB agendas and minutes,
- A review of workload, performance metrics, and annual reports,
- A review of stakeholder satisfaction surveys,
- An assessment of QC procedures for compliance with the SOPs,
- A review of checklists, forms, and templates,
- Interviews with REB members, REB Office Personnel, Researchers, Sponsors, and regulators,
- A review of training/education records,
- A review of all continuous improvement activities,
- An assessment of whether any new requirements (ethical, legal, or regulatory) were incorporated into the policies and procedures,
- A review of the status of any corrective action items from previous reviews,
- A review of any deviations from ethical, legal, or regulatory requirements, or deviations from the organization's policies, and whether the deviations require remediation,
- An assessment of compliance with all applicable requirements;

5.1.4 The QA Officer compares the findings against established policies, SOPs, and applicable ethical, legal, and regulatory requirements;

5.1.5 The QA Officer prepares a written summary of the inspection, including areas requiring improvement;

5.1.6 The QA Officer reports the findings to the REB Chair or Designee, and to the REB and/or to the appropriate Organizational Official as required;

5.1.7 The QA Officer works with the REB Chair or Designee to implement improvements (e.g., new or revised SOPs or forms, training, education, additional resources or modifications to existing resources).

5.2 Researcher Quality Assurance Inspections

5.2.1 The QA Officer will develop a schedule for routine QA inspections and implement inspections in response to Researcher requests;

5.2.2 The QA Officer will work with the REB and the organization at which the research is being conducted to determine if and when a for-cause inspection of a Researcher is warranted;

5.2.3 The REB may direct the QA Officer to conduct for-cause inspections;

5.2.4 The QA Officer or Designee may request copies of the Sponsor's monitoring reports for a designated research project or that a questionnaire from the REB is completed;

5.2.5 The criteria for selecting Researchers or research projects for inspection may include:

- The results of a previous external audit or inspection,
- The results of a Sponsor audit,
- Researcher-initiated studies (i.e., where the Researcher is also the Sponsor),
- Studies that involve a potentially high risk to Participants,
- Studies that involve vulnerable populations, (in the context of research)
- Studies in which Researchers are enrolling large numbers of Participants,
- Suspected noncompliance,
- Unanticipated problems involving risks to Participants or others,
- Suspected or reported protocol deviations,
- Participant complaints,
- Research Staff complaints,
- Any other situation that the REB deems appropriate;

5.2.6 The QA Officer or Designee will notify the Researcher of the inspection, and a mutually acceptable time will be scheduled. It may be necessary to schedule an inspection without first obtaining the formal consent of a Researcher (e.g., Participant safety or suspected non-compliance);

5.2.7 The QA Officer or Designee will conduct the inspection using designated/ appropriate evaluation tools;

5.2.8 When the QA Officer conducts an inspection of the Researcher, the inspection may include some or all of the following (as applicable):

- An assessment of the SOPs and compliance with applicable regulations and guidance,
- A review of all regulatory binders including the REB approval documentation, REB approved consent documents, signed consent documents, correspondence between the Researcher and Sponsor, etc.,
- Interviews with the research staff and/or the Researcher,
- A review of test article accountability,
- A review of specimens and associated collection processes,
- A review of computer hardware and/or software associated with the research,
- A review of the consent form(s) and associated processes including eligibility requirements,
- A review of the completed case report forms (CRFs) or other data collection mechanisms,
- A review of appropriate source material (e.g., Participant medical records), and
- A review of other documentation, as relevant and available;

5.2.9 The REB or the QA Officer may choose to have a qualified impartial observer to monitor the consent process or to interview research Participants;

5.2.10 At the conclusion of the evaluation, the QA Officer or Designee will discuss the findings with the Researcher;

5.2.11 The QA Officer or Designee will draft a report or provide a summary of the inspection including positive findings, areas for improvement and recommendations for corrective action, and submit the report to the REB Chair or Designee for review;

5.2.12 The Researcher will be given an opportunity to respond to the report with responses and/or corrective action plans within a time specified by the REB;

5.2.13 The QA Officer or Designee will send a copy of the final report to the Researcher and the REB. When applicable, the REB Chair or Designee will provide the findings to the local Organizational Official.

5.3 Corrective Action

5.3.1 The QA Officer may recommend corrective action based on the findings;

5.3.2 Corrective action may include a recommendation for the provision of additional resources, training, or education, the development of, or revisions to the SOPs, and changes to forms, checklists or templates;

5.3.3 The QA Officer will evaluate the effectiveness of the implemented improvements and adjust processes accordingly;

5.3.4 The QA Officer will follow up with the Researcher in a timely manner to determine if the corrective actions have been implemented by the Researcher following a Researcher audit or inspection.

5.4 Documentation

5.4.1 The QA Officer or Designee files all reports and correspondence concerning QA inspections in the appropriate QA Files.

6.0 REFERENCES

See References.

7.0 REVISION HISTORY

SOP Code	Effective Date	Summary of Changes
SOP901.001	15-Sept-2014	Original version
SOP901.002	08-Mar-2016	No revisions needed
SOP901.003	08-Oct-2019	5.2.5: addition of the following in the fifth bullet – vulnerable ‘(in the context of research)’
SOP901.004	15-May-2023	No revisions needed
SOP901.005	14-Apr-2026	2.0: replaced ‘guidelines’ with ‘responsibilities’

Title	External Inspections or Audits
SOP Code	902.005
Effective Date	14-Apr-2026

Site Approvals

Name and Title (typed or printed)	Signature	Date dd/Mon/yyyy

1.0 PURPOSE

This standard operating procedure (SOP) describes the procedures to be followed before, during, and following an external inspection or audit.

2.0 SCOPE

This SOP pertains to Research Ethics Boards (REB) that review human Participant research in compliance with applicable regulations and policies.

3.0 RESPONSIBILITIES

All REB members, REB Office Personnel, and Researchers are responsible for ensuring that the requirements of this SOP are met.

4.0 DEFINITIONS

See Glossary of Terms.

5.0 PROCEDURE

Health Canada has the authority to inspect Researcher sites conducting clinical trials that fall under the *Regulations* to assess compliance with relevant regulations, policies, and guidelines.

The US Food and Drug Administration (FDA) has the authority to audit Researcher sites involved in studies conducted under a US Investigated New Drug Application (IND) or Investigational Device Exemption (IDE) to assess compliance with relevant regulations and guidelines. The US Office for Human Research Protection (OHRP) has the authority to audit Canadian REBs that oversee studies that are supported by the US federal government.

Sponsors, funding entities, or others authorized by regulations or agreements with the organizations may have the authority to audit or inspect research-related documents and procedures.

These audits or inspections may involve the REB; therefore, the REB must have policies in place for dealing with external audits or inspections. The Researcher is responsible for notifying the REB of any planned audits or inspections of research projects overseen by the REB.

5.1 Preparing for an Inspection or Audit

5.1.1 The Sponsor and/or the Researcher (or inspector/auditor, as applicable) will notify the REB Chair or Designee regarding the agreed dates and times of the inspection/audit, and verify the purpose of the inspection/audit, the applicable project(s) undergoing inspection/audit, and the inspection/audit plan and procedures;

5.1.2 The REB Chair or Designee will notify the REB members and the REB Office Personnel of the inspection/audit;

5.1.3 The REB Chair or Designee will review the inspection/audit procedures with the REB members and REB Office Personnel, and conduct a thorough review of the required documentation;

5.1.4 The REB Chair or Designee will arrange for access to the appropriate documents for the inspector/auditor;

5.1.5 The REB Chair or Designee will confirm that the REB members and REB Office Personnel are available for interviews or to assist the inspector/auditor;

5.1.6 The REB Chair or Designee will arrange for a suitable work area, e.g., private and with sufficient space, with access to equipment as needed e.g. a computer with electronic access to the files to be inspected, a photocopier for the inspector/auditor.

5.2 Participating in an Inspection or Audit

5.2.1 The REB Chair or Designee will meet with the inspector/auditor as scheduled. Prior to being granted access to the research-specific REB documentation, the inspector/auditor must exhibit proof of authority or authorization to conduct the inspection/audit;

5.2.2 The REB Chair or Designee will record the name, contact information, and title of the inspector/auditor and retain any written notices of inspection/audit for the REB files;

5.2.3 The REB Chair or Designee will provide a brief orientation to the inspector/auditor of REB procedures;

5.2.4 The REB Chair or Designee will provide access to the research-specific documents requested by the inspector/auditor and maintain a list of the documents reviewed;

5.2.5 The REB Chair or Designee will accompany the inspector/auditor at all times while in confidential areas of the REB office and/or the organization;

5.2.6 The REB Chair or Designee will ensure that the inspector/auditor's questions are answered by the most appropriate personnel. The REB Chair or Designee, REB Office Personnel and REB members must make every reasonable effort to be available and to accommodate the requests of the inspector/auditor;

5.2.7 The REB Chair or Designee will request meetings with the inspector/auditor at the end of each day, as needed, to discuss any observations. If questions are asked or observations are made during the daily meetings, the REB Chair or designee will research the issues and provide the inspector/auditor with clarification as soon as possible once the information is available;

5.2.8 The REB Chair or Designee will ensure that the required personnel are present at the exit interview and that observations are understood before the inspector/auditors leave the facility;

5.2.9 The REB Chair or Designee will record any observations of the inspector/auditor and any discussion and ascertain when/if a written response is required.

5.3 Follow-up after an Inspection or Audit

5.3.1 The Researcher is responsible for sharing a copy of reports with the REB Chair or Designee ;

5.3.2 The REB Chair or Designee and any other designated individuals will review any findings relevant to the REB and prepare a written response to each item or observation, including any clarification or corrective action that will be taken. The response to the inspector/auditor should be coordinated through the appropriate channels (e.g., the Sponsor via the Researcher);

5.3.3 The REB Chair or Designee and any other designated individuals will institute any correction actions as applicable and revise the REB SOPs as needed;

5.3.4 The REB Chair or Designee will file the original inspection/audit and response documents in the appropriate files (e.g., quality assurance).

6.0 REFERENCES

See References.

7.0 REVISION HISTORY

SOP Code	Effective Date	Summary of Changes
SOP902.001	15-Sept-2014	Original version
SOP902.002	08-Mar-2016	No revisions needed
SOP902.003	08-Oct-2019	No revisions needed
SOP902.004	15-May-2023	No revisions needed
SOP902.005	14-Apr-2026	2.0: replaced ‘guidelines’ with ‘policies’. 5.0: paragraph 1, added ‘policies’. 5.1.1: edited to indicate the correct party responsible for notification of the audit. 5.1.6: deleted ‘with access to a computer and in close proximity to a photocopier and telephone’; added ‘with access to electronic files for inspection’. 5.3.1: edited to indicate the correct party responsible for sharing reports.

Title	Non-Compliance
SOP Code	903.005
Effective Date	14-Apr-2026

Site Approvals

Name and Title (typed or printed)	Signature	Date dd/Mon/yyyy

1.0 PURPOSE

This standard operating procedure (SOP) describes the Research Ethics Board's (REB) process for responding to reports of non-compliance and the actions that the REB may take as a result of its review of reports of serious and/or continuing non-compliance.

2.0 SCOPE

This SOP pertains to REBs that review human Participant research in compliance with applicable regulations and policies.

3.0 RESPONSIBILITIES

All REB members, REB Office Personnel, and Researchers are responsible for ensuring that the requirements of this SOP are met.

Researchers are required to comply with all of the applicable guidelines, policies, and regulations governing the conduct of human research, as well as with the required conditions of approval of the REB.

The REB Office Personnel and the REB members are responsible for acting on information or reports of non-compliance received from any source.

The REB Chair or Designee is responsible for the initial review of allegations of non-compliance.

If intentional, serious, or continuing non-compliance is established, the REB is responsible for determining the relevant corrective actions.

The REB is responsible for reporting any incidents of serious or continuing non-compliance to the Researcher and to the appropriate Organizational Official(s) and has the authority to notify the regulatory authorities (as applicable), and the Sponsor. The REB may delegate regulatory authority reporting (as applicable) to the organization.

4.0 DEFINITIONS

See Glossary of Terms.

5.0 PROCEDURE

Reports of non-compliance may come from any source including the REB members, Researchers, research Participants, organizational personnel, the media, or the public. The rights and welfare of research Participants could be at risk if there were serious or repeated non-compliance on the part of a Researcher or any member of the research team. It is, therefore, the duty of the REB to be receptive to these reports and to act on all credible allegations of non-compliance.

5.1 Reports of Non-compliance

5.1.1 Reports of non-compliance in human Participant research may come from many sources including, but not limited to, a Researcher (as a self-report), a Sponsor representative, a quality assurance or compliance office, a research Participant, a member of the research team, or a person not directly involved with the research;

5.1.2 Persons raising such concerns are encouraged to express them in writing. However, the REB office will receive and document oral reports of non-compliance;

5.1.3 Evidence of serious or repeated non-compliance may also arise from human protection-related Quality Assurance inspections, Sponsor audits or inspections, or regulatory agency audits or inspections.

5.2 Evaluating Allegations of Non-compliance

5.2.1 When an allegation of non-compliance is referred to the REB, the REB Office Personnel will document the information and the contact details of the person reporting the allegation, and immediately refer the incident to the REB Chair or Designee;

5.2.2 The REB Chair or Designee manages all allegations of non-compliance and reports of non-compliance that are determined to be more than minor;

5.2.3 The REB Chair or Designee will conduct an initial review of all allegations to determine the veracity of the allegations;

5.2.4 The REB Chair or Designee will obtain as much information as possible from the individual reporting the incident;

5.2.5 The REB Chair or Designee will obtain as much information as possible, or verification from other sources by one or more of the following means:

- Contacting the Researcher or member of the investigative team directly,
- Consulting with other relevant organizational personnel,
- Collecting relevant documentation,
- Reviewing any written materials,
- Interviewing knowledgeable sources;

5.2.6 If the REB Chair or Designee determines that there is evidence of non-compliance, they will then assess whether the non-compliance was intentional, serious, and/or repeated;

5.2.7 If the REB Chair or Designee determines that there is no or insufficient evidence to support the allegations, no further action will be required.

5.3 Managing Non-compliance

5.3.1 The REB will attempt to resolve apparent instances of non-compliance without interrupting the conduct of the research, especially if the rights and welfare of Participants may be jeopardized by interrupting the research;

5.3.2 If the REB Chair or Designee determines that the non-compliance was not serious or repeated, and the research staff recognized the non-compliance and took appropriate corrective actions, no further action may be required;

5.3.3 If the REB Chair or Designee determines that the non-compliance was not serious or repeated, but the research staff did not recognize the non-compliance or take appropriate corrective actions, the REB Chair or Designee may discuss the matter directly with the Researcher, recommend corrective action, request a Quality Assurance evaluation, and/or refer the matter to the REB at a Full Board meeting;

5.3.4 If it appears that a Researcher was intentionally non-compliant, the REB Chair or Designee may suspend the conduct of the research immediately and refer the matter to the next Full Board meeting of the REB, and will inform the Organizational Official;

5.3.5 The REB will review the information at the next Full Board meeting and determine the appropriate corrective actions;

5.3.6 Corrective actions are based upon the nature and the degree of non-compliance. In evaluating the non-compliance, the REB may consider one or more of the following actions:

- Request modification of the protocol,
- Request modification of the informed consent document,
- Require that additional information be provided to past Participants,
- Require that current Participants be notified,
- Require that current Participants re-consent to participation,
- Modify the continuing review schedule,
- Require onsite observation of the consent process,
- Suspend the new enrollment of Participants,
- Suspend REB approval of the research,
- Suspend Researcher involvement in the research,
- Terminate REB approval of the research,
- Require the Researcher and/or staff to complete a training program,
- Notify organizational entities (e.g., legal counsel, risk management),
- Ensure that all other regulatory reporting requirements are met, as required,
- Any other action deemed appropriate by the REB.

5.4 REB Response to Reports of Non-compliance

5.4.1 The REB Chair or Designee will notify the Researcher in writing of the results of the REB review of incidents of non-compliance and any remedial actions required;

5.4.2 The REB Chair or Designee will report any serious or continuing non-compliance to the Researcher as well as to the Organizational Official(s) and has the authority to report to the regulatory authorities (as applicable) and the Sponsor. The REB may delegate regulatory authority reporting to the organization;

5.4.3 The REB may submit an allegation of research misconduct to the Organization Official as appropriate;

5.4.4 The REB will request a time-sensitive response in writing from the Researcher, including the corrective action plan;

5.4.5 The Researcher's response may be reviewed using a Delegated REB review procedure or the review may be referred to the REB, for a decision from the Full Board;

5.4.6 The REB Chair or Designee will follow up to assess any corrective measures implemented by the Researcher.

5.5 Documenting Non-compliance

5.5.1 The REB Chair or Designee will document the findings of reports of non-compliance. The report will include the allegations, the information obtained during the initial assessment, whether allegations of non-compliance were verified, the REB's decision and actions taken, and the Researcher's response;

5.5.2 For those incidents of non-compliance referred to the Full Board, the REB Office Personnel will document the following in the REB meeting minutes: a description of the incident and findings, verification of the non-compliance, the REB's decision, the remedial action required by the REB, the Researcher's response and actions implemented, and plans for further follow-up.

6.0 REFERENCES

See References.

7.0 REVISION HISTORY

SOP Code	Effective Date	Summary of Changes
SOP903.001	15-Sept-2014	Original version
SOP903.002	08-Mar-2016	No revisions needed
SOP903.003	08-Oct-2019	No revisions needed
SOP903.004	15-May-2023	No revisions needed
SOP903.005	14-Apr-2026	2.0, 3.0: changed ‘guidelines’ to ‘policies’.

Glossary of Terms

Ad hoc advisor: a person with relevant and competent knowledge and expertise consulted by a Research Ethics Board (REB) for a specific research ethics review, and for the duration of that review, in the event that the REB members lack specific expertise or knowledge to review with competence the ethical acceptability of a research proposal. The ad hoc advisor is not a member of the REB and is not counted in the quorum or allowed to vote on REB decisions.

Adverse event (AE): any untoward medical occurrence in a research participant, administered investigational product, including an occurrence which does not have a causal relationship with this product. An AE can therefore be any unfavourable and unintended sign (including an abnormal laboratory finding, for example), symptom, or disease temporally associated with the use of an investigational product, whether or not related to the investigational product.

Local adverse event: those adverse events experienced by research participants enrolled by the Researcher at the centre(s) under the jurisdiction of the Research Ethics Board (REB).

Non-local (external) adverse event (EAE): those adverse events experienced by research participants enrolled by Researchers at other centres/organizations outside the REB's jurisdiction.

Serious Adverse Event (SAE) or Serious Adverse Drug Reaction (ADR): any untoward medical occurrence that at any dose: results in death, is life threatening, requires inpatient hospitalization of prolongation of existing hospitalization, results in persistent or significant disability/incapacity or is a congenital anomaly/birth defect.

Alternate member: a formally appointed voting member of the Research Ethics Board (REB) who may substitute for a regular member of the REB, but who is not expected to attend every REB meeting. An alternate REB member's presence at the REB meeting in the place of an absent regular REB member is used to establish quorum.

Amendment: a written description of a modification or change(s) to the previously approved research study. Amendments include any changes to the protocol or related research documents, such as changes to the consent form, revisions to the Investigator Brochure, updated participant material, etc.

Appeal committee: the President & CEO shall establish or appoint an Appeal committee that reflects a range of expertise and knowledge similar to that of the REB. The composition of the Appeal committee, as well as its terms of membership and quorum requirements must satisfy the REB requirements in the TCPS2.

Assent: affirmative agreement to participate in research by an individual unable to provide consent.

Authorized signatory: individual(s) authorized to sign documents on behalf of an organization.

Authorized third party: Any person with the necessary authority to make decisions on behalf of the prospective participant who lacks the capacity to consent to participate, or to continue to participate, in a particular research project. (Also known as a "legally acceptable representative" or "substitute decision-maker").

Clinical Equipoise: the existence of genuine uncertainty on the part of the relevant expert community about which interventions are most effective for a given condition.

Confidentiality: refers to the agreement between the Researcher and the participant as to how personal data will be managed and used, and an ethical and/or legal responsibility to safeguard information from unauthorized use, disclosure, modification, loss or theft. The term also refers to the REB's ethical and/or legal responsibility to safeguard information in its custody from unauthorized use, disclosure, modification, loss or theft.

Conflict of Interest (COI): circumstance of a person (e.g., Researcher or Research Ethics Board (REB) member) or organization in a real, perceived or potential conflict between their duties or responsibilities related to research and their personal, institutional or other (secondary) interests.

Example: COI may occur when an individual's judgments and actions or an organization's actions in relation to research are, or could be, affected by personal, organizational or other interests, including, but not limited to, business, commercial or financial interests, whether of individuals, their family members, their friends, or their former, current or prospective professional associations or of the organization itself.

Examples of secondary interests for a Researcher include the following:

- Is receiving or expecting to receive compensation from the Sponsor in which the value of the compensation could be affected by the outcome of the study;
- Acts as an officer, director, or agent of the Sponsor;
- Their job status or compensation is impacted by the research (e.g., payment for speaking or leading study groups on behalf of the Sponsor);
- Is receiving a finder's fee for the recruitment of research participants;
- Has a proprietary interest (e.g., patent, trademark, copyright interest, licensing agreement) in the tested product;
- Has (or family, spouse, close relationships) any equity interest in the Sponsor;
- Receives payments of other sorts, which are made by the Sponsor exclusive of the costs of conducting the clinical research (e.g., a grant to fund ongoing research, compensation in the form of equipment or retainers for ongoing consultation or honoraria);
- Is intending to recruit their own patients as research participants;
- Has identified him or herself for any other reason as having a conflicting interest (i.e., organizational conflict that may impact the research).

Examples of secondary interests for an REB member include the following:

- Is a Researcher or sub-Researcher on the protocol;

- Is directly involved in the conduct of the research;
- Their job status or compensation is impacted by the research (e.g., research coordinator, payment for speaking/leading study groups on behalf of the Sponsor);
- Is receiving or expecting to receive compensation from the Sponsor in which the value of the compensation could be affected by the outcome of the study;
- Acts as an officer, director, or agent of the Sponsor;
- Has a proprietary interest (e.g., patent, trademark, copyright interest, licensing agreement) in the tested product;
- Has any equity interest in the Sponsor that when aggregated for the member and the member's spouse and dependent children;
- Any equity interest in the Sponsor (i.e., any ownership interest, stock options, or other financial interest whose value cannot be readily determined through reference to public prices);
- Significant payments of other sorts, which are payments made by the Sponsor exclusive of the costs of conducting the clinical research (e.g., a grant to fund ongoing research, compensation in the form of equipment or retainers for ongoing consultation or honoraria);
- Is in direct competition with the Researcher of the research project for limited resources, funding, sponsorship, or research participants; acts as a consultant for the Sponsor; is considered a personal or professional adversary of the Researcher;
- Has identified him or herself for any other reason as having a conflicting interest.

Continuing research ethics review (also referred to as "continuing review"): any review of ongoing research conducted by a Research Ethics Board (REB) occurring after the date of initial REB approval and continuing throughout the life of the project to ensure that all stages of a research project are ethically acceptable in accordance with the principles in the Policy.

Controlled forms: documents that require formal change control, and that form part of the permanent record of Research Ethics Board (REB) operations and processes.

Corrective action: a measure or intervention adopted to eliminate the causes of nonconformity, defect, or undesirable situation, with the aim of preventing its recurrence.

Creative practice: A process through which an artist makes or interprets a work, or works, of art. It may also include a study of the process of how a work of art is generated.

Data Minimization: A privacy principle requiring that only the personal data necessary to achieve the research purpose is collected, accessed, or retained.

Data and Safety Monitoring Board (DSMB): a multi-disciplinary, expert advisory group established by a research Sponsor, that is responsible for safeguarding the interests of participants by reviewing emerging data**,** assessing the safety and efficacy of research procedures, and monitoring the overall conduct of the research.

Debriefing: The full disclosure of the research purpose and other pertinent information to participants who have been involved in research employing partial disclosure or deception. Debriefing is typically done after participation has ended but may be done at any time during the study.

Delegated review (also referred to as expedited review): the level of Research Ethics Board (REB) review assigned to minimal risk research studies, to minor changes in approved research and to continuing review applications that meet the delegated review criteria. Delegated reviewers are selected from among the REB membership to conduct the review.

Designee: may refer to a member of the Research Ethics Board (REB) or to the REB Office Personnel depending on the context of the statement and the accompanying requirements of the organization**.**

Expiry date: the first day that the Research Ethics Board (REB) approval of the research is no longer valid without further review and approval by the REB. When the REB determines that review more than annually is required, the expiration date will be determined by the REB (e.g., six months from the date of the approval).

Full Research Ethics Board (REB) review: the level of Research Ethics Board (REB) review assigned to above minimal risk research studies. Conducted by the full membership of the REB, it is the default requirement for the ethics review of research involving human participants.

Generalized: the extent to which results or finding obtained from a sample are applicable to a broader population.

Human genetic research: the study of genetic factors responsible for human traits and the interaction of those factors with each other, and with the environment.

Impartial: without prejudice or bias, fair; a principle of justice holding that decisions should be based on objective criteria, rather than on the basis of bias, prejudice, or preferring the benefit to one person over another.

Impracticable: incapable of being put into practice due to a degree of hardship or onerousness that jeopardizes the conduct of the research; it does not mean mere inconvenience.

Incentive: anything offered to research participants, monetary or otherwise, to encourage participation in research.

Incidental findings: unanticipated discoveries made in the course of research that are outside the scope of the research. Material incidental findings are findings that have been interpreted as having significant welfare implications for the participant, whether health-

related, psychological or social. If, in the course of research, material incidental findings are discovered, Researchers have an obligation to inform the participant.

Indigenous peoples: In Canada, the term “Indigenous peoples” refers to persons of Indian (First Nations), Inuit, or Metis descent, regardless of where they reside and whether their names appear on an official register. In Canada, a comparable term, “Aboriginal peoples,” is also used in certain contexts.

Inspection: a systematic examination and evaluation of study-related activities and documents in comparison to specified requirements and standards.

Institutional conflicts of interest: an incompatibility between two or more substantial institutional obligations that cannot be adequately fulfilled without compromising one or another of the obligations

Investigational product: refers to new or new uses of drugs, biologics, medical devices or natural health products.

Mature minor: is an individual who demonstrates adequate understanding and decision-making capacity.

Medical device trials: clinical trials that test the safety and/or efficacy of one or more instruments used in the prevention, diagnosis, mitigation, or treatment of a disease or abnormal physical condition or the restoration, correction or modification of body function or structure.

Minimal risk: research in which the probability and magnitude of possible harms implied by participation in the research is no greater than those encountered by participants in those aspects of their everyday life that relate to the research.

Minor change: any change that would not materially affect an assessment of the risks and benefits of the research or the integrity of the data and does not substantially change the specific aims or design of the study.

Multi-centred: multi-centre means that the research is reasonably expected to be conducted at more than one centre.

Natural health product (NHP) trial: a clinical trial testing the safety and/or efficacy of one or more natural health products (NHP). The term NHP is used to describe substances such as vitamins and minerals, herbal medicines, homeopathic preparations, energy drinks, probiotics, and many alternative and traditional medicines.

Non-compliance: failure to follow applicable guidelines and regulations governing human participant research; failure to follow the protocol approved by the Research Ethics Board (REB), or failure to follow stipulations imposed by the REB as a condition of approval.

Non-controlled forms: documents that are not part of the permanent record of Research Ethics Board (REB) operations and processes. Non-controlled forms also will contain version dates.

Ongoing research: research that has received Research Ethics Board (REB) approval and has not yet been completed.

Organizational Official: a senior official who signs an organization's human participants' assurance, making a commitment on behalf of the organization to comply with 45 CFR Part 46, the US Code of Federal Regulations covering protection of human participants, and with Health Canada regulations.

Participant: an individual whose data or responses to interventions, stimuli, or questions by a Researcher are relevant to answering a research question; also referred to as "human participant" and in other policies/guidance as "subject" or "research subject."

Periodic safety update or summary report: a summary report, created by the Sponsor, listing all of the reported unexpected serious adverse events that have occurred in a given reporting period, and which includes any significant areas of concern and the evolving safety profile of the investigational product.

Personal health information: Personal health information (PHI), is a subset of **Personal information** which is identifiable information about an individual. (See "Identifiable information" which also is "personal information")

Personal health information is identifying information about an individual in either an oral or in a recorded form, if the information:

- Relates to the individual's physical or mental health, including family health history;
- Relates to the provision of health care, including the identification of persons providing care;
- Is a plan of service for an individual requiring long-term care;
- Relates to payment or eligibility for health care;
- Relates to the donation of body parts or bodily substances or is derived from the testing, or examination of such parts or substances;
- Is the individual's health number; or
- Identifies an individual's substitute decision-maker.

Any other information about an individual that is included in a record containing personal health information is also included in this definition. This definition does not include information about an individual if the information could not reasonably be used to identify the individual.

Personal information (also referred to as "identifiable information"): information that identifies an individual and/or for which it is foreseeable that may reasonably be expected to identify an individual, alone or in combination with other available information.

Directly identifying information: the information identifies a specific individual through direct identifiers (e.g., name, social insurance number, personal health number).

Indirectly identifying information: the information can reasonably be expected to identify an individual through a combination of indirect identifiers (e.g., date of birth, place of residence, or unique personal characteristic).

Coded information: direct identifiers are removed from the information and replaced with a code. Depending on access to the code, it may be possible to re-identify specific participants (e.g., the Researcher retains a list that links the participant's code name with their actual name so data can be re-linked if necessary).

Anonymized information: the information is irrevocably stripped of direct identifiers, a code is not kept to allow future re-linkage, and risk of re-identification of individuals from remaining indirect identifiers is low or very low.

Anonymous information: the information never had identifiers associated with it (e.g., anonymous surveys) and risk of identification of individuals is low or very low.

Privacy: an individual's right to be free from intrusion or interference by others.
Privacy refers to persons and their interest in controlling the access of others to themselves (their personal information).

Privacy breach: the unauthorized collection, use, or disclosure of personal information or personal health information (PHI) in the custody and control of an individual or a Health Information Custodian (HIC) or in the custody and control of the organization or its affiliated partners.

Proportionate approach to research ethics review: the assessment of foreseeable risk to determine the level of scrutiny the research will receive (i.e., delegated review for minimal risk research or full Research Ethics Board (REB) review for research above minimal risk), as well as the consideration of foreseeable risks, potential benefits, and ethical implications of the research in the context of initial and continuing review.

Protocol deviation: the term protocol deviation is not well defined by regulations or guidelines, but deviations are identified as any unplanned or unforeseen change to a Research Ethics Board (REB) approved protocol or protocol procedures. Deviations are different from amendments in that they generally apply to a single occurrence or participant and are not intended at the time to modify the entire protocol.

Quorum:
Quorum shall include at least five (5) voting members, including (at minimum):

- two (2) members with expertise in the relevant disciplines, fields and methodologies covered by the REB (for biomedical clinical trials, this will include at least one member who practices medicine or dentistry and who is in good standing with their regulatory body),
- one (1) member who is primarily experienced in non-scientific disciplines
- one (1) member knowledgeable in ethics

- one (1) member from the community who has no affiliation with the organization(s) and who is not part of the immediate family of a person who is affiliated with the organization
- one (1) member knowledgeable in the relevant law (for biomedical research) additional representation as required by applicable legislation or guidelines

For research subject to the US Code of Federal Regulations, quorum shall also include a majority (50%+1) of voting members.

Reportable event: includes anything that could significantly impact the conduct of the research or alter the Research Ethics Board's (REB) approval or favourable opinion to continue the research.

Research: an undertaking intended to extend knowledge through a disciplined inquiry or systematic investigation.

Researcher: the leader of a research team who is responsible for the conduct of the research, and for the actions of any member of the research team. (Also known as "Qualified Investigator").

Research Ethics Board (REB): a body of Researchers, community members, and others with specific expertise (e.g., in ethics, in relevant research disciplines) established by an organization to review the ethical acceptability of all research involving humans conducted within the organization's jurisdiction or under its auspices.

Research Ethics Board (REB) of record: the Research Ethics Board (REB) that has been granted ultimate authority for the ethics review and oversight of a research study.

Risk: the possibility of the occurrence of harm. The level of foreseeable risk posed to participants by their involvement in research is assessed by considering the magnitude or seriousness of the harm and the probability that it will occur, whether to participants or third parties.

Secondary Use: the use in research of information or human biological materials originally collected for a purpose other than the current research purpose.

Suspension: a temporary or permanent halt to all research activities pending future action by the Research Ethics Board (REB), by the Sponsor and/or by the Researcher.

Termination: a permanent halt by the Research Ethics Board (REB), by the Sponsor and/or by the Researcher to all or some research activities.

Unanticipated issues: issues that occur during the conduct of research; may increase the level of risk to participants or have other ethical implications that may affect

participants' welfare; and were not anticipated by the Researcher in the research proposal submitted for research ethics review.

Unanticipated problem: any incident, experience, or outcome (including an adverse event) that meets **all** of the following criteria:

- ***Unexpected** (in terms of nature, severity, or frequency) given (a) the research procedures that are described in the protocol-related documents, such as the Research Ethics Board (REB) approved research protocol and informed consent document, or the Investigator Brochure; and (b) the characteristics of the research participant population being studied; **and**
- **+Related or possibly related** to participation in the research, (possibly related means there is a reasonable possibility that the incident, experience, or outcome may have been caused by the [investigational product(s)] or procedures involved in the research); **and**
- Suggests that the research **places research participants or others at a greater risk of harm** (including physical, psychological, economic, or social harm) than was previously known or recognized.

  ***Unexpected:** an event is "unexpected" when its specificity and severity are not accurately reflected in the protocol-related documents such as the Research Ethics Board (REB) approved research protocol, the Investigator Brochure, or the current REB approved informed consent document, or other relevant sources of information such as product labelling and package inserts; or when the event is not associated with the expected natural progression of any underlying disease, disorder, predisposing risk factor, or condition of the participant(s) experiencing the adverse event.

  +Related to the research procedures: an event is "related to the research procedures" if in the opinion of the Researcher or Sponsor, the event was more likely than not to be caused by the research procedures.

Vulnerability: a diminished ability to fully safeguard one's own interests in the context of a specific research project. This may be caused by limited decision-making capacity or limited access to social goods, such as rights, opportunities and power. Individuals or groups may experience vulnerability to different degrees and at different times, depending on their circumstances.

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3. Natural Health Products Regulations: Part 4, Clinical Trials Involving Human Subjects
4. Medical Devices Regulations: Part 3, Medical Devices for Investigational Testing Involving Human Subjects
5. Personal Information Protection and Electronic Documents Act
6. United States Code of Federal Regulations: 21 CFR 50, 56, 312, 812 and 45 CFR 46
7. ICH GCP International Council on Harmonisation of Technical Requirements for Registration of Pharmaceuticals for Human Use – ICH Harmonised Tripartite Guideline – Guidelines for Good Clinical Practice E6(R3)
8. Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada, Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans, TCPS2 2022
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33. Canadian Institutes for Health Research. Best Practices for Protecting Privacy in Health Research (September 2005)
34. APA Dictionary of Psychology (2018) *Generalizability* retrieved November 14, 2025, from APA Dictionary of Psychology
35. "Generalizability." Oxford English Dictionary, Oxford University Press (2016) retrieved November 14, 2025, from Generalizability - Oxford Reference.

Table of Concordance

Source Criteria	Addressed in SOP:	Additional Guidance
International Council on Harmonisation Good Clinical Practice Guidelines		
1.2.1	101	
1.2.2	301 402 403 404 701 801	REBs are advised to have supporting material documenting compliance (e.g. application forms and documentation outlining the requirement material, in accordance with this element).
		This language on investigator qualifications is now covered in 1.2.2 (h)
1.2.4	402 403 405	
1.2.5	101 701	
	403 701	The E6 R2 language in 3.1.6 does not carry over to E6 R3.
1.2.6	403 701	
1.2.8	403	
3.1.9 1.2.9	701	REBs are advised to have supporting materials documenting compliance (e.g. an Informed Consent requirements checklist or template consent addressing these criteria).
1.3.1	105A 201 202	
3.2.2 1.3.2	302 All	REBs are advised to have supporting materials documenting compliance (e.g. documenting compliance with written SOPs)
3.2.3 1.3.3	Glossary of Terms 302	
1.3.4	302	
1.3.5	201 302	
1.3.6	201	
1.4.1	101 201	
1.4.2	302	
1.4.3	402 403 405	
1.4.4	402 403 405	
1.4.5	401	
1.4.6	102	
1.4.7	404	
1.4.8	404	E6 R3 language changed from “adverse drug reactions that are both serious and unexpected” to “suspected unexpected serious adverse reactions”

Table of Concordance

Source Criteria	Addressed in SOP:	Additional Guidance
1.4.9	402 407 601	
1.5	303	E6 R3 language removes "...for a period of at least 3 years after completion of the trial"; it defers to applicable regulatory requirements.
Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS2)		
1.1	101	
2.1	102	
2.2	102	
2.3	102	
2.4	102	
2.5	102	
2.6	102	
2.7	403	
2.8	405	
2.9	401 403 404 405	
2.10	403	
2.11	403	
3.1	403 701	
3.2	403 701	
3.3	701	
3.4	403 701	
3.5	403 701	
3.6		Outside of the scope of the SOPs
3.7A and 3.7B	403 701	
3.8	403 701	
3.9	403 702	
3.10.	403 703	
3.11	701	
3.12	403, 701	
3.13	701	
4.1	403	
4.2	403	
4.3	403	
4.4	403	

Table of Concordance

Source Criteria	Addressed in SOP:	Additional Guidance
4.5	403	
4.6	403	This SOP does not repeat the specific list outlined in TCPS2. These criteria have been grouped under a broader heading. REBs are expected to consider all applicable aspects as part of their deliberations.
4.7	403	
4.8	403	
5.1		Outside of the scope of the SOPs (describes researcher/organizational responsibility). REB aspects are addressed in SOPs as outlined in this table.
5.2	107 403 701	
5.3	107 403	
5.4		Outside of the scope of the SOPs (describes researcher/organizational responsibility). REB aspects are addressed in SOPs as outlined in this table.
5.5A and 5.5B	403 701	
5.6	701	
5.7	102 301 403	This SOP does not repeat the specific list outlined in TCPS2. These criteria have been grouped under a broader heading. REBs are expected to consider all applicable aspects as part of their deliberations.
6.1	101	
6.2	101	Aspects of this element are the responsibility of the institution and are outside the scope of this set of SOPs. REBs are advised to have supporting material documenting compliance (e.g. describing the reporting requirements to the highest body within an institution, etc.).
6.3	101 404	
6.4	201	REBs are advised to have supporting materials documenting compliance (e.g. REB membership list addressing these requirements).
6.5	201	
6.6	202	
6.7	103 201 202 203	
6.8	203	
6.9	Glossary of Terms 201 302	
6.10.	302	
6.11	102	

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Source Criteria	Addressed in SOP:	Additional Guidance
6.12	401 403 404 405	
6.13	105A 601	
6.14	405	
6.15	404 801	
6.16	404 801	
6.17	302 303 402	
6.18	402	
6.19	402	
6.20.	402	
6.21	501	
6.22	501	
6.23	501	
6.24		Outside of the scope of the SOPs (describes organizational responsibility).
7.1	105A-C	
7.2	105B-C	
7.3	105A	
7.4	105B 801	
8.1-8.4		Outside of the scope of the SOPs (describes organizational responsibility).
9.1-9.22	403	This SOP does not repeat the specific criteria outlined in TCPS2. These criteria have been grouped under a broader heading. REBs are expected to consider all applicable aspects as part of their deliberations.
10.1	102	
10.2	301	
10.3	403 701	
10.4	107 403 701	
10.5	301	
11.1	403	
11.2	403	
11.3	403	
11.4	403	
11.5	403	

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Source Criteria	Addressed in SOP:	Additional Guidance
11.6	403 701	Reviewed; no changes needed.
11.7	301 403	Reviewed; no changes needed.
11.8	404 407 701	Reviewed; no changes needed.
11.9	404	Reviewed; no changes needed.
11.10.	403	TCPS2 Article 11.10 pertains to clinical trial registries. SOPs 105A, 105B and 105C pertain to Conflict of Interest and are silent on clinical trial registration. 403 is good as is.
11.11		TCPS2 Article 11.11 pertains to researcher responsibility to update the clinical trials registry entry in a timely manner. Both 105B and 403 are silent on this. I did not find reference to clinical trial registration in another SOP.
		No Article 11.12 in the 2022 version.
12.1	102 701	Article 12.1 does not speak to waiver of consent conditions, only that consent is required, whereas 701 describes waiver of consent.
12.2		Article 12.2 describes the additional information researchers must provide to participants (on top of Article 3.2 requirements) when seeking consent for use of human biological materials. SOP 701 does not specifically address this. I did not see it in another SOP.
12.3A and 12.3B	701	Reviewed, no changes needed.
12.4	701	Article 12.4 describes researchers' need to have an REB-approved plan for contacting participants for ***additional*** biological materials (or other reasons). SOP does not specifically speak to this very specific scenario, but does contain a detailed Recruitment section.
12.5		Outside of the scope of the SOPs (describes researcher/organizational responsibility).
12.6	403	Reviewed; no changes needed.
12.7 – 12.13	102	Covers research involving human embryos.
12.14 – 12.18, 12.20		Out of scope for the REB.
12.19	105B and 105C	
12.21		The SOPs do not speak specifically to exemption from REB review for research that relies exclusively on de-identified human somatic cell lines.
12.22		The SOPs do not speak specifically to exemption from REB review for research that relies exclusively on the re-use of identified human somatic cell lines.
United States Code of Federal Regulations		
45 CFR 46.107(a) 21 CFR 56.107(a)	201	Reviewed; no changes required.
21 CFR 56.107(b)	201	Reviewed; no changes required.
45 CFR 46.107(b) 21 CFR 56.107(c)	201	Reviewed; no changes required.
45 CFR 46.107(c) 21 CFR 56.107(d)	201	
45 CFR 46.107(d) 21 CFR 56.107(e)	105A	

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Source Criteria	Addressed in SOP:	Additional Guidance
45 CFR 46.107(e) 21 CFR 56.107(f)	201	Reviewed; no changes required.
45 CFR 46.108(a)(2)/ 21 CFR 56.115(a)(5)	202	No section 103(b)(3) in the revised 45CFR46.
45 CFR 46.108(a)(3)/ 21 CFR 56.115(a)(6)/ 21 CFR 56.108(a)	403 404 405 601	21CFR56.115(a)(6) correspond to SOP 302. 21CFR56.108(a) corresponds to SOP 101.
45 CFR 46.108(a)(4)/ 21 CFR 56.115(a)(6)/ 21 CFR 56.108(b)	404 407 903	There is no longer a subsection 5 in 45CFR46.103(b). 45CFR46.108a is compared above. 21CFR56.108 is compared above.
45 CFR 46.108(b) 21 CFR 56.108(c)	 302 401	Note: the Glossary of Terms corresponds to 45CFR46.102 and 21CFR56.102.
		Original page 5 ended with 'Glossary of Terms'. This copy ran over into page 6 because of added notes.
45 CFR 46.109(a) 21 CFR 56.109(a)	402	
45 CFR 46.109(b) 21 CFR 56.109(b)	701	
45 CFR 46.109(c) 21 CFR 56.109(c)	701	
45 CFR 46.109(d) 21 CFR 56.109(e)	402 601	
45 CFR 46.109(e) 21 CFR 56.109(f)	405	
45 CFR 46.110(b) 21 CFR 56.110(b)	401	
45 CFR 46.110(c) 21 CFR 56.110(c)	401 302	
45 CFR 46.110(d) 21 CFR 56.110(d)		Outside of the scope of the SOPs (describes Regulatory Authority responsibility).
45 CFR 46.111(a)(1) 21 CFR 56.111(a)(1)	403	
45 CFR 46.111(a)(2) 21 CFR 56.111(a)(2)	403	
45 CFR 46.111(a)(3) 21 CFR 56.111(a)(3)	403	
45 CFR 46.111(a)(4) 21 CFR 56.111(a)(4)	403 701	
45 CFR 46.111(a)(5) 21 CFR 56.111(a)(5)	403 701	
45 CFR 46.111(a)(6) 21 CFR 56.111(a)(6)	403	
45 CFR 46.111(a)(7) 21 CFR 56.111(a)(7)	403	
45 CFR 46.111(b) 21 CFR 56.111(b)	403	

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Source Criteria	Addressed in SOP:	Additional Guidance
45 CFR 46.112 21 CFR 56.112		Outside of the scope of the SOPs (describes organizational responsibility).
45 CFR 46.113 21 CFR 56.113	407	
45 CFR 46.114 21 CFR 56.114		Outside of the scope of the SOPs (describes organizational Responsibility and refers to institutions located in the Unites States).
45 CFR 46.115(a)(1) 21 CFR 56.115(a)(1)	303	
45 CFR 46.115(a)(2) 21 CFR 56.115(a)(2)	302 303	
45 CFR 46.115(a)(3) 21 CFR 56.115(a)(3)	303	
45 CFR 46.115(a)(4) 21 CFR 56.115(a)(4)	303	
45 CFR 46.115(a)(5) 21 CFR 56.115(a)(5)	202 303	
45 CFR 46.115(a)(6) 21 CFR 56.115(a)(6)	403 404 405 407 601 903	
45 CFR 46.115(a)(7) 21 CFR 56.115(a)(7)	701	
45 CFR 46.115(a)(8)	401	IRB documentation to include: "The rationale for an expedited reviewer's determination …that research … is more than minimal"
45 CFR 46.115(b) 21 CFR 56.115(b)	303 902	
45 CFR 46.116(a) 21 CFR 50.25(a)	701	REBs are advised to have supporting materials documenting compliance (e.g. an Informed Consent template addressing these criteria).
45 CFR 46.116(b) 21 CFR 50.25(b)	701	REBs are advised to have supporting materials documenting compliance (e.g. an Informed Consent requirements template addressing these criteria).
45 CFR 46.116(c)	701	REBs are advised to have supporting materials documenting compliance (e.g. an Informed Consent requirements template addressing these criteria). The Cancer Committee template ICF addresses these criteria.
45 CFR 46.116(d)	701	REBs are advised to have supporting materials documenting compliance (e.g. an Informed Consent requirements template addressing these criteria).
45 CFR 46.116(e)	701	
45 CFR 46.116(f)	701	
45 CFR 46.117(a) 21 CFR 50.27(a)	701	
45 CFR 46.117(b) 21 CFR 50.27(b)	701	
45 CFR 46.117(c)	701	
45 CFR 46 Subpart B, C, D 21 CFR 50 Subpart D	101 403 701	In SOP 701, S. 5.10.3, add the reference to 21 CFR 50 Subpart D

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Source Criteria	Addressed in SOP:	Additional Guidance
21 CFR 56.109(d)	701	21 CFR 56.109(d) states: "In cases where the documentation requirement is waived under paragraph (c)(1) of this section, the IRB may require the investigator to provide subjects with a written statement regarding the research."
21 CFR 56.109(h)	403 701	
21 CFR 50.23 (a) and (c) 21 CFR 50.24	701	
21 CFR 50.25(c)	701	REBs are advised to have supporting materials documenting compliance (e.g. an Informed Consent requirements checklist or template consent addressing these criteria).
21 CFR 50.25(d) and (e)		Outside the scope of these SOPs.
21 CFR 50.20	701	
21 CFR 56.23(a)	701	