

*Argosy University*  
*San Francisco Bay Area Campus*

**Final Clinical Research Project Approval Form**

Student Name: \_\_\_\_\_ SSN: \_\_\_\_\_  
(*print name*)

Title of CRP: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

CRP Committee: \_\_\_\_\_  
(*print names*)      Chair  
  
\_\_\_\_\_  
Reader

**CLINICAL RESEARCH PROJECT COMMITTEE APPROVAL**  
(Signature indicates final approval of the Clinical Research Project by the CRP Committee)

\_\_\_\_\_  
Committee Chair (signature)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Reader (signature)

\_\_\_\_\_  
Date

Please submit the completed form to the IRB.

Copies of completed form to: Student, CRP Committee Chair, IRB