



Annual Report

Clinical Trials of Investigational Stem Cell Treatment

NOTICE: THE INFORMATION IS PUBLICLY AVAILABLE

Report Year September 1, to August 31,

1. NAME AND ADDRESS OF THE INSTITUTIONAL REVIEW BOARD (IRB)

Name of IRB

Address 1

Address 2

City

State

ZIP or Postal Code

Email Address

Phone

2. NAME AND ADDRESS OF ALL MEDICAL SCHOOLS AND HOSPITALS AFFILIATED WITH THE IRB

Note: The IRB must be affiliated with a medical school as defined by Section 61.501 of the Education Code or a hospital licensed under Chapter 241 of the Texas Health and Safety Code that has at least 150 beds.

Name of Medical School or Hospital

Address 1

Address 2

City

State

ZIP or Postal Code

3. NAME AND ADDRESS OF PATIENT TREATMENT LOCATION(S) (Attach TMB-MD-0002-A if more space is necessary)

Treatment Location 1

Address

City

State

Zip

Treatment Location 2

Address

City

State

Zip

Treatment Location 3

Address

City

State

Zip

Treatment Location 4

Address

City

State

Zip

4. PHYSICIAN NAMES CERTIFIED BY THE IRB OR AFFILIATED ENTITY (Attach TMB-MD-0003-A if more space is necessary)

5. Provide a summary below containing the following information.

1. Sets forth the study's current findings.
2. Specifies the total number of patients participating in the stem cell clinical trials(s).
3. Includes the treatment results of all patients treated with investigational stem cell treatments.
4. Generally describes the effects of the treatments and all adverse events.

Do not include any patient identifying information

6. Indicate the top three treatment areas of the study.

- 1.
- 2.
- 3.

7. SIGNATURE - I certify that the contents of and attachments to this document are complete and accurate.

SIGNATURE OF IRB CHAIRPERSON



DATE (mm/dd/yyyy)