

Print or Type Information:

Full Name _____

Degree(s)
All relevant academic degrees _____

Credentials
License(s) _____

Certification Professional
Certification(s) _____

Relationship to Sparrow Health System
Medical Staff, Staff, Consultant,
None _____

Primary Scientific or Non-Scientific Specialty

Complete Mailing Address

Phone: _____ **Fax:** _____ **Pager or Cell Phone:** _____

E-mail Address: _____

Return completed questionnaire along with your signed IRB Appointment Acceptance letter to:

IRRC/Office of Research Oversight and Compliance
Sparrow Health System
1215 E Michigan Avenue, PO Box 30480
Lansing, MI 48909-7980