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**CERTIFICATE OF STUDY CLOSURE**

The undersigned hereby certifies that MDH IRB approved (#: \_\_\_\_\_\_) study protocol entitled

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

was closed on *(indicate date of study closure here)*: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ .

This protocol was:

□ Completed and then closed

□ Closed prior to completion (*why?* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

Previously released Medicaid data have been returned by the undersigned to:

□ MDH *(attach written confirmation of receipt)*

□ Data Provider (e.g., the Hilltop Institute) *(attach written confirmation of receipt)*

 OR

Previously released Medicaid data have been destroyed *(attach Certificate of Data Destruction)*

□ By the following method: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Principal Investigator’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Principal Investigator’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Principal Investigator’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please submit required CLOSING SUMMARY of protocol-specific activities and outcomes, along with this completed form, to:** **mdh.medicaiddatarequests@maryland.gov** **.**