**Sample Consent Form**

**It is impossible to address all scenarios for the many types of research protocols conducted by MUSC researchers. This sample is designed to assist you in the preparation of consent forms. It is intended to show language preferred by the MUSC IRB to address the essential elements of informed consent. In many cases, the sample language will need to be modified, deleted, or expanded for the particular study.**

Shaded paragraphs like this one are instructions/guidance for you, the writer. Do not include them in the consent form you submit.

*Paragraphs in italics like this are intended to be copied and pasted verbatim into the consent form, when applicable.*

**Use this sample consent form as a guide for writing consent and/or assent**

**Formatting Instructions:**

* For the participants’ ease of readability it is strongly recommended that you use no smaller than 12 point font.
* Write the consent form in the 2nd person (i.e. you) and keep the pronoun usage consistent throughout.
* Use page numbers (such as *Page X of Y)*
* Use the watermark provided on the IRB forms page and do not alter the watermark. Leave an area approximately 1 inch by 2 inches on the bottom of each page for the IRB approval stamp. (The watermark template on the forms page automatically provides the required margin.)

**Use understandable, non-technical language at an 8th-grade or lower reading level:**

* Do not use symbols (i.e. >, <)
* Provide standard measurements when describing the amount of samples to be used. Convert milliliters to teaspoons/tablespoons. Only one standard measurement is required. (Conversions: 5ml = 1 teaspoon; 15 ml= 1 tablespoon)
* Spell out acronyms the first time they are used.
* Avoid exculpatory statements such as “you understand.”
* Readability statistics can be displayed in Microsoft Word. Search Microsoft Office Help for “readability statistics” for further instructions.
* Make sure to use spell check and proof the document for grammar before submission.

**Please also use the** [**Suggested Consent Language Library**](https://research.musc.edu/resources/ori/irb/forms/consent-language) **for sample language to be used to describe specific procedures and risks of those procedures.**

**DELETE THIS FIRST PAGE OF INFORMATION**

**IF YOU ARE USING THIS DOCUMENT**

**TO CREATE YOUR CONSENT FORM.**

**Medical University of South Carolina
CONSENT TO BE A RESEARCH SUBJECT**

**TITLE OF RESEARCH:** Insert study title

* The Consent form study title must match the title on all documents (i.e. protocol, eIRB application full title, HIPAA authorization, 1572, surveys, etc.).
* If the study involves using different consent forms for different populations, identify the population group as the subtitle of the study.

**RESEARCH INVOLVING CHILDREN:**

* When the study is only enrolling children, and a parent or guardian will be providing consent, or the child will sign a separate assent form, , use “your child” throughout the form.
* When a parent or guardian is providing consent for both him/herself and the child participant, specify throughout the consent form when you are referring to the parent and when you are referring to the child. This would allow for the use of “you,” “your child,” and “you and your child” throughout the form.
* If the study will enroll both minors and adults as participants (but not parent/child pairs), insert the following language beneath the title of the study:

*If participants include those under 18 years of age: 1) The subject's parent or legal guardian will be present when the informed consent form is provided. 2) The subject will be able to participate only if the parent or legal guardian provides permission and the adolescent provides his/her assent. 3) In statements below, the word "you" refers to your child or adolescent who is being asked to participate in the study.*

**A. PURPOSE OF THE RESEARCH**

* Explain the purpose of the study in nontechnical language.
* Describe why the participant is being asked to join.
* State that the study involves research.
* Studies of drugs/devices or comparison of procedures should include a statement that the purpose of the study includes an evaluation of the safety and effectiveness of the article or procedure.
* If the study is using an investigational drug, drug combination, biologic and/or device, always indicate what is FDA approved and what is investigational. (Investigational means the study drug or device or biologic is still being tested in research studies and is not approved by the U.S. Food and Drug Administration.)
* If applicable, explain what a Pilot, Phase I, II, III, or IV drug study is.
* State the total planned number of participants to be enrolled by the MUSC investigator, and study wide for multicenter studies.
* If the study is a corporate sponsored study, include the following statement in the purpose section: “MUSC, the study team and the Principal Investigator will be paid to conduct the study.”
* If applicable, include the following language, “A grant from the National Institutes of Health (NIH) will sponsor this study. Portions of the (PI’s name) and his/her research team’s salaries will be paid by this grant.”

You are being asked to volunteer for a research study. Research studies are voluntary and include only people who choose to take part. Please read this consent form carefully and take your time making your decision. As your study doctor or study staff discusses this consent form with you, please ask him/her to explain any words or information that you do not clearly understand. The purpose of this study is to \_\_\_\_\_. You are being asked to participate in this study because you are/have \_\_\_\_\_\_. The study is sponsored by \_\_\_\_\_\_\_\_. The investigator in charge of this study is \_\_\_\_\_\_ (PI’s name). The study is being done at \_\_\_\_\_ (insert the number) sites. Approximately\_\_\_\_ people will take part study-wide and \_\_\_\_\_ will take part at MUSC.

**B. PROCEDURES**

**\*\***Refer to the [Suggested Consent Language Library](http://research.musc.edu/research/ori/irb/forms/consent-language) for sample language to be used to describe specific procedures.

* Procedures should be listed in chronological order.
* Describe the research procedures to be followed. Give sufficient detail for the subject to understand the full extent of his/her participation.
* Standard of care procedures (SOC) do not need to be described in the consent document. There are certain types of studies (e.g. oncology studies, comparative effectiveness studies) where some description of SOC is inevitable.
* Identify all drugs, devices, and procedures that are experimental. This also includes all drugs or devices that have FDA approved indications but are being used in this investigation for non-approved indications.
* If applicable, describe randomization procedures and blinding for the participant.
* If the study will use a placebo, please define placebo. For example, “A placebo is an inactive substance given in the same form as the active drug.”
* Estimate the amount of time involved for the study visits.
* If both pregnancy testing and illicit drug testing will occur in the same study, the pregnancy test and a negative result from that pregnancy test should be obtained prior to performing the illicit drug test.
* If applicable, include a section that addresses the precautions that should be taken by women of childbearing potential and /or by men capable of fathering a child before, during, and/or after participation. List the specific acceptable methods of birth control for participants involved in the study. Use only the information that is applicable to the study population.
* For complex studies with many visits, include visit times in the procedures sections (lay out a timeline); or consider inserting a table/study calendar to assist in describing the study.
* If specimens (e.g., blood, tissue, body fluids) will be collected as part of the research procedures, describe the collection in this section. If the specimens will be stored for future research, describe the storage procedures later in this consent form under “Storage of Specimens for Future Use”.
* If research-only imaging studies are part of the protocol, address whether or not the images will be read for incidental findings. If the images will not be read for incidental findings, include the suggested risk language for incidental findings.
* If applicable, include a section outlining reasons why a participant may be withdrawn from the study or include the ramifications of a participant’s decision to withdraw from the research.
	+ Include procedures for orderly termination of participation (i.e. end of treatment visit, tapering schedule, exit interview).

If you agree to be in this study, the following will happen:

1. You will need to have the following exams, tests or procedures to find out if you can be in the study. These exams, tests or procedures are part of regular care and may be done even if you do not join the study. If you have had some of them recently, they may not need to be repeated. This will be up to your study doctor.

 OR:

 You will have the following tests and procedures to make sure that you are eligible:

* List/Describe each test/procedure

 OR:

 The researchers will check your medical records to gather information about ….

2. You will have a physical examination and blood and urine will be collected for laboratory tests. Approximately \_\_\_\_ teaspoons (or other commonly understood units such as tablespoons) of blood will be drawn for these tests to \_\_\_\_\_\_.

3. If the physical examination and test results show that you are eligible for the study, you will be randomly assigned to one of two groups. This means that you have a 50/50 chance (like flipping a coin) of being in either group. Neither the researchers nor you will make the choice to which group you are assigned. The two groups are Group A (Drug \_\_\_\_) and Group B (placebo, an inactive substance).

OR, for studies with more than two arms:

You will be randomly assigned to one of ­­­\_\_\_\_ groups, like drawing numbers from a hat.

4. Group A will receive \_\_\_\_\_, the investigational drug, \_\_\_ times a days for \_\_\_ weeks for a total of \_\_\_\_weeks. Group B will receive placebo, according to the same schedule.

5. An imaging exam of your \_\_\_\_\_\_ will be done once at the beginning of the study, and again at the end of the study, in order to check \_\_\_\_. Each procedure will take about \_\_\_\_ minutes/hour(s).

6. Once every two weeks, you will have a Magnetic Resonance Imaging (MRI) exam. For the MRI exam, you will …

7. If you are a woman of childbearing potential and/or a man capable of fathering a child before, during, and/or after participation precaution should be taken. Examples of acceptable methods of birth control for participants involved in the study includes: birth control pills, patch, IUD, condom, sponge, diaphragm with spermicide, or avoiding sexual activity that could cause you to become pregnant.

**C. DURATION**

Include the total duration of the study in this section.

Participation in the study will take about \_\_\_\_\_visits over a period of \_\_\_\_\_days/weeks/months.

**D. RISKS AND DISCOMFORTS**

**\*\***Refer to the [Suggested Consent Language Library](http://research.musc.edu/research/ori/irb/forms/consent-language) for sample language to be used to describe the risks of specific procedures.

* Include any foreseeable risks or discomforts to the participant including physical, social, financial, loss of employability, reputation, and breach of confidentiality.
* The risk section should only contain the risks associated with study procedures. Do not include risks or discomforts associated with drugs or interventions that are not being administered or performed as part of this study. Generally, risks of standard of care procedures should not be included in the consent form.
* Give details of all risks and or discomforts. List risks in order of relative frequency and provide the expected frequency.
* Use sub-headers if there are multiple types of risks

Common adverse events occurring in approximately \_\_\_% of subjects:

(List)

Less common adverse events occurring in \_\_\_% of subjects:

(List)

OR:

*There is a risk of a loss of confidentiality of your personal information as a result of participation in this study.*

OR:

There is a risk of loss of privacy as a result of participation in the group discussions.

**E. BENEFITS**

* State any potential benefits to the participant or to others (e.g. future patients) that may reasonably be expected to benefit from the research.
* Do not overstate benefits.
* If there is no potential for direct benefit to the participant, clearly state this.
* **Do not include** medication, treatment, devices, or compensation as a benefit.

There will be no direct benefit to you from participating in this study. However, it is hoped that the information gained from the study will help in the treatment of future patients with conditions like yours/will help the researcher learn more about\_\_\_\_\_\_\_\_\_.

OR, if the subject is randomized:

The potential benefit to you is that the treatment you receive may prove to be more effective than the other study treatment or than other available treatments, although this cannot be guaranteed.

If you are in the group that receives Drug \_\_\_\_\_ and it is successful in treating your condition with fewer side effects than the current standard therapy, you may benefit from participating in the study; however, this cannot be guaranteed.

**F. COSTS**

If your study is subject to PRA review, please insert the following language. (If you receive a PRA summary memo with consent language that differs from the language below, please defer to the PRA memo language.):

*The study drug/device, \_\_\_\_\_\_\_ (Drug/Device name), will be provided to you at no cost. There will be no additional cost to you for procedures required in this research study that are for research purposes only. All routine clinical care that the Sponsor is not paying for that you would have undergone without participation in the study will be billed to you/your insurance company.*

*Some insurance plans will not pay for these services for people taking part in research studies. You will be responsible for any charges that your insurance does not cover including co-payments and deductibles.*

*Please ask \_\_\_\_\_\_\_ (PI’s name) if you would like to know more about which tests and studies are being done solely for research purposes.*

If the study is PRA exempt and there is no cost to the study participant, please insert the following language:

*There will be no cost to you as a result of participation in this study.*

In addition to the above language, please add a description of other potential costs that would be specific to your study (e.g., cell phone data costs, travel costs, etc.).

**G. PAYMENT TO PARTICIPANTS**

* Payment should be dispersed as the study progresses and cannot be contingent upon the subject completing the study.
* Include amount, payment schedule, and method of payment (checks, cash, gift certificates/cards, pre-paid debit card, personal property, and other items of value).
	+ If the intended method of payment is a pre-paid debit card via MUSC’s ClinCard program, include the ClinCard language from the Suggested Consent Language Library. Click here to access: [ClinCard](https://research.musc.edu/resources/ori/irb/forms/consent-language/greenphire-clincard).
* Describe prorated payments for participants who withdraw before the end of the study.
* If children are involved, specify whether the child or parent is being paid.

You will not be paid for participating in this study.

OR:

In return for your time and effort, you will be paid $\_\_\_\_\_ for participation in this study. If you do not complete the study, you will receive $\_\_\_\_\_for each completed visit.

The following language is required if subjects are being paid for participation:

*Payments that you receive from MUSC for participating in a research study are considered taxable income per IRS regulations. Payment types may include, but are not limited to: checks, cash, gift certificates/cards, personal property, and other items of value. If the total amount of payment you receive from MUSC reaches or exceeds $600.00 in a calendar year, you will be issued a Form 1099.*

**H. ALTERNATIVES**

* Describe all appropriate alternative treatment, if any, of treatment that might be advantageous to the subject.
* To enable a rational choice to participate in the research study, subjects should be aware of the full range of options available to them. The person obtaining the subject’s consent should be able to discuss available alternatives including side effects of these alternatives and answer questions that the subject may raise about them.
* One alternative should be to not participate in the study.

If you choose not to participate in this study, you could receive other treatments for your condition. The standard therapy for your condition is …

OR:

Your alternative is to not participate in this study.

**OPTIONAL SECTIONS:**

Include any of the following additional elements of consent as applicable. Continue to use outline format (I., J., K., etc.).

**NOTE**: If the intent of planned research is to purposely recruit and enroll students or employees from the Institution and they are selected in the eIRB application as a targeted population, include the applicable section(s) in the Informed Consent Form. If recruitment of students and employees is just incidental and they are not a targeted population, the sections are not required in the Informed Consent Form.

\_\_\_\_ **SIGNIFICANT NEW FINDINGS**

Usually applicable for treatment studies, the significant new findings section should indicate whether significant new findings developed during the course of the research that may relate to the participant’s willingness to continue participation would be provided to the participant by the principal investigator or his/her staff.

If there are significant new findings during the course of the study, you will be notified*.*

**\_\_\_STUDENT PARTICIPATION**

*Your participation or discontinuance will not constitute an element of your academic performance, nor will it be a part of your academic record at this Institution.*

**\_\_\_EMPLOYEE PARTICIPATION**

*Your participation or discontinuance will not constitute an element of your job performance or evaluation, nor will it be a part of your personnel record at this Institution.*

**\_\_\_CERTIFICATE OF CONFIDENTIALITY**

If a DHHS Confidentiality Certificate has been obtained, include something like the following paragraph.

Researchers should include language such as the following if they intend to make voluntary disclosure about things such as child abuse, intent to hurt self or others, or other voluntary disclosures.-

To help us protect your privacy, we have obtained a Certificate of Confidentiality from the National Institutes of Health. The researchers can use this Certificate to legally refuse to disclose information that may identify you in any federal, state, or local civil, criminal, administrative, legislative, or other proceedings, for example, if there is a court subpoena. The researchers will use the Certificate to resist any demands for information that would identify you, except as explained below.

The Certificate cannot be used to resist a demand for information from personnel of the United States Government that is used for auditing or evaluation of federally funded projects or for information that must be disclosed in order to meet the requirements of the federal Food and Drug Administration (FDA).

A Certificate of Confidentiality does not prevent you or a member of your family from voluntarily releasing information about yourself or your involvement in this research. If an insurer, employer, or other person obtains your written consent to receive research information, then the researchers may not use the Certificate to withhold that information.

Include language such as the following if you intend to make voluntary disclosure about things such as child abuse, intent to hurt self or others, or other voluntary disclosures.

The Certificate of Confidentiality will not be used to prevent disclosure to state or local authorities of [list what will be reported, such as child abuse and neglect, or harm to self or others].

\_\_\_**CLINICAL TRIALS.GOV**

For applicable clinical trials, include the statement below. It is the responsibility of the sponsors and investigators to determine if their clinical trial meets the definition of an “applicable clinical trial” and to ensure compliance with the most current applicable statutory and regulatory requirements.

*A description of this clinical trial will be available on* [*http://www.ClinicalTrials.gov*](http://www.ClinicalTrials.gov)*, as required by U.S. Law. This Web site will not include information that can identify you. At most, the Web site will include a summary of the results. You can search this Web site at any time.*

\_\_\_**SPONSOR COMMITMENT**

Sponsoring companies often request that their own wording be used for treatment and compensation for study related injuries. Sponsors may include a description of what the sponsor will cover in this section only. The wording of MUSC’s standard paragraphs at the end of the consent form was formulated with the advice of legal counsel with the intent of adhering to the requirements of Federal and State regulations and cannot be changed.

**\_\_\_\_STORAGE OF SPECIMENS FOR FUTURE USE**

If specimens (e.g. blood, tissue) obtained for the research may be stored for future research not specifically defined in the protocol, include this section. At a minimum, address the following points and include lines for participants to initial (do not use checkboxes):

* What kind of specimens will be collected and the means of collection
* What type of research will be done with the specimens
* Specify whether genetic research may be performed on the samples
* Whether the specimens will be shared with other investigators
* Whether the specimens will be coded or anonymized (no way of tracing back to participant/uncoded or code destroyed)
* Whether the participant may be contacted for additional consent (they typically are not contacted for additional consent)
* How long, if known, the biological specimens will be stored (short-term: current protocol only or other current research; long-term: future studies on disease or condition, repository, etc.)
* Foreseeable risks or benefits to participants in the collection, storage, and subsequent research use of specimens
* What will be done with the biological specimens if the participant refuses permission
* What will be done with the research results (research results should not be placed in the individual participant’s medical record)
* Potential for commercial use of the subject’s specimen(s)
* How to withdraw consent for future use (if specimens are identifiable)

If samples to be stored will be **linked** to the identity of the participant:

As part of this study, we would like to store \_\_\_\_ (type of specimen, blood, urine, tissue, etc.) specimens collected from you for future research on \_\_\_\_ (condition). This future research may be conducted by \_\_\_\_ (PI’s name) or by other researchers who obtain IRB approval for their research. This research may/ will not (choose which is correct) involve genetic studies. There are several things you should know before allowing your (tissues, cells, urine, and/or blood) to be studied or to be stored.

1. The specimens will be labeled with a code that only study personnel can link back to you. Researchers outside of this study will not be given a link between the code number and your name or any other identifying information. While we hope this will prevent any potential loss of privacy or confidentiality, we cannot make any guarantees.
2. In addition to your name, other information about you might be connected to your sample. For instance, information about race, ethnicity, sex, your medical history, and so forth might be available to investigators studying your specimen. Such information might be important for research or public health. It is possible that this information (including genetic information) might come to be associated with your racial or ethnic group.
3. The specimens obtained from you in this research may help in the development of a future commercial product. There are no plans to provide financial compensation to you should this occur.

 If no re-contact is planned:

1. In this study, investigators will not tell you what they find out about you, nor will they contact you if a test becomes available to diagnose a condition you might have or later develop.

 OR, if potential re-contact is planned:

4. Investigators in this study may try to re-contact you in the future to find out about your health. If you are contacted and want to know what the investigators have learned about your samples, you should understand that the following are the kinds of things the investigators or your health team might tell you:

a. Information is too preliminary to give you particular details, but you will receive a newsletter informing you about the results of the project.

b. For any future research, we may contact you with a new consent form giving you additional information.

If including genetic testing also add the info below:

 c. You carry a gene for a particular disease that can be treated.

d. You carry a gene for a particular disease for which there is no current treatment. This news might cause severe anxiety or other psychological distress, depending on the severity of the disease.

e. You carry a gene for a disease and might consider informing relatives that they, too, might carry the gene. It can be very difficult to decide whether to share such information with relatives. Genetic counselors can help sort out the various options in such a case.

You do not have to agree to allow your blood and urine specimens to be stored in order to be part of this study.

You may request at any time that your research samples be removed from storage and not be used for future research. If you decide you want your samples removed, you may contact \_\_\_\_\_ (PI’s name) via written communication at the following address: \_\_\_\_\_\_\_\_\_\_\_\_\_. Once the request is received, and if your samples have not already been used for other research, they will be destroyed. If you do not make such a request, your specimens will be stored indefinitely or until completely used.

Initial your choice below:

\_\_\_ Yes, I agree to allow my samples to be kept and used for future research.

\_\_\_ No, I do not agree to allow my samples to be kept and used for future research.

OR, if samples to be stored are **un-linked** to the identity of the participant:

As part of this study, we would like to store \_\_\_\_ (type of specimen, blood, urine, tissue, etc.) specimens collected from you for future research on \_\_\_\_\_ (condition). This future research may be conducted by \_\_\_\_ (PI’s name) or by other researchers who obtain IRB approval for their research. This research may/ will not involve genetic studies. The specimens will be de-identified/anonymized. This will protect your confidentiality and anonymity; it will also have other consequences:

1. It will be impossible to withdraw these samples from any future research project. Your sample cannot be destroyed if it has been de-identified and can no longer be traced back to you.
2. Results of any future research will not be given to you or your doctor.
3. Even though your name and other personal identifiers will not be connected to the sample, other information about you might still be connected. For instance, information about your race, ethnicity, sex, your medical history, and so forth might be available to investigators studying your specimen. Such information might be important for research or public health. It is possible that this information (including genetic information) might come to be associated with your racial or ethnic group.
4. The specimens obtained from you in this research may help in the development of a future commercial product. There are no plans to provide financial compensation to you should this occur.

You do not have to agree to allow your blood and urine specimens to be stored in order to be part of this study.

Initial your choice below:

\_\_\_ Yes, I agree to allow my samples to be kept and used for future research.

\_\_\_ No, I do not agree to allow my samples to be kept and used for future research.

**\_\_\_FUTURE CONTACT**

The researcher in charge of this study might like to contact you in the future about other research opportunities. Please initial by your choice below:

\_\_\_\_Yes, I agree to be contacted.

\_\_\_\_No, I do not agree to be contacted.

**MUSC STANDARD PARAGRAPHS:**

* The following information must be included in all informed consents as required by Federal regulations and MUSC IRB policies. They are commitments and/or responses to Federal regulations by this Institution. **The paragraphs cannot be edited or altered without prior approval of general counsel.**
* **Exception to Edits: “your child” and “you and your child” may be added without prior approval of general counsel.**

Results of this research will be used for the purposes described in this study. This information may be published, but you will not be identified. Information that is obtained concerning this research that can be identified with you will remain confidential to the extent possible within State and Federal law. The investigators associated with this study, the sponsor, and the MUSC Institutional Review Board for Human Research will have access to identifying information. If this study is being overseen by the Food and Drug Administration (FDA), they may review your research records. All records in South Carolina are subject to subpoena by a court of law.

In the event that you are injured as a result of participation in this study, you should immediately go to the emergency room of the Medical University Hospital, or in case of an emergency go to the nearest hospital, and tell the physician on call that you are in a research study. They will call your study doctor who will make arrangements for your treatment. If the study sponsor does not pay for your treatment, the Medical University Hospital and the physicians who render treatment to you will bill your insurance company. If your insurance company denies coverage or insurance is not available, you will be responsible for payment for all services rendered to you.

Your participation in this study is voluntary. You may refuse to take part in or stop taking part in this study at any time. You should call the investigator in charge of this study if you decide to do this. Your decision not to take part in the study will not affect your current or future medical care or any benefits to which you are entitled.

The investigators and/or the sponsor may stop your participation in this study at any time if they decide it is in your best interest. They may also do this if you do not follow the investigator’s instructions.

**Volunteers Statement**

I have been given a chance to ask questions about this research study. These questions have been answered to my satisfaction. If I have any more questions about my participation in this study or study related injury, I may contact ***PI NAME at PHONE NUMBER***. I may contact the Medical University of SC Patient and Family Care Liaison (843) 792-5555 concerning medical treatment.

If I have any questions, problems, or concerns, desire further information or wish to offer input, I may contact the Medical University of SC Institutional Review Board for Human Research IRB Manager or the Office of Research Integrity Director at (843) 792-4148. This includes any questions about my rights as a research subject in this study.

I agree to participate in this study. I have been given a copy of this form for my own records.

**Signature Blocks:**

**It is not possible to address all scenarios for signature requirements that may be needed for various types of research. These instructions and samples are designed to assist you in the preparation of the Signatures section. In many cases, the Signatures section will need to be customized for the particular study population**

* Select the signature block the applies to the study.
* Please make sure to review the signature block and account for all signature lines needed. For example, if children are being enrolled in the study, personal representative (legally authorized representative) and minor assent lines would need to be a part of the signature block.

**Standard Signature Block for Enrolling Adult Participants**

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

Signature of Participant Date Name of Participant

Signature of Person Obtaining Consent          Date

OR

**Signature Block for Enrolling Decisionally Impaired Adult Participants -LAR consent**

Name of Participant

Participant’s Personal Representative:

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

Name of Personal Representative *(Please print)*

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

Signature of Personal Representative Date

Relationship:  \_\_\_ Spouse       \_\_\_ Parent               \_\_\_Next of Kin         \_\_\_Legal Guardian\* \_\_\_\_ DPOA for Healthcare\*

*\*(If you are the health care agent or guardian, please provide proof of your authority to act on behalf of the patient)*

Signature of Person Obtaining Consent              Date

OR

**Signature Block for Enrolling Minor Participants - Parent/Guardian Permission**

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

Name of Participant

Participant’s Personal Representative:

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

Name of Personal Representative *(Please print)*

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

Signature of Personal Representative Date

Relationship:  \_\_\_ Spouse       \_\_\_ Parent               \_\_\_Next of Kin         \_\_\_Legal Guardian\* \_\_\_\_ DPOA for Healthcare\*

*\*(If you are the health care agent or guardian, please provide proof of your authority to act on behalf of the patient)*

\*For Minors 12-17 years of age: “My participation has been explained to me, and all of my questions have been answered. I am willing to participate.”

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Person Obtaining Consent             Date

OR

**Signature Block for Enrolling Adults and Minors as Participants**

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

Signature of Adult Participant Date Printed Name of Adult Participant

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

Printed Name of Minor Participant

Participant’s Personal Representative:

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

Signature of Participant’s Personal Representative (if applicable) Date

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

Printed Name of Personal Representative (if applicable)

Relationship:  \_\_\_ Spouse       \_\_\_ Parent               \_\_\_Next of Kin         \_\_\_Legal Guardian\* \_\_\_\_ DPOA for Healthcare\*

*\*(If you are the health care agent or guardian, please provide proof of your authority to act on behalf of the patient)*

\*For Minors 12-17 years of age: “My participation has been explained to me, and all of my questions have been answered. I am willing to participate.”

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Person Obtaining Consent Date