

## Research Participant Informed Consent Form

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**Title of Study:** *Insert Title of Research Study*  
*Insert Study Number*

**Principal Investigator:** *Name of the Principal Investigator*  
*Department of Principal Investigator*  
*Applicable Medical Center*  
*Address*  
*Phone Numbers*

**Emergency Contact:** *Insert Emergency Contact*  
*Insert Phone Number/Pager, etc.*

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### About volunteering for this research study

You are being asked to join a research study, which will take place at **[insert institution name]**. This form tells important information about the research. A member of the research team will also speak with you about taking part in this study. People who take part in research studies are called “participants”. This term will be used throughout the consent form.

You should ask questions of the person who is explaining this form to you. After you feel that you understand the research, if you want to be part of the study, you will be asked to sign the form. You can always ask more questions and can later change your mind about staying in the study. You will receive a copy of this form for your keeping.

You are a potential participant in this study because [insert reason the potential participant may qualify to be in the study]. Overall, this study will enroll **[insert number of subjects]** participants.

### What is the purpose of this study and how much time will it take? *[For social/behavioral studies]*

Your participation in this research study will last *[Include participant's time in hours, days, weeks, months, years in appropriate terms for the objectives of the study]*

The purpose of this research study is to **[describe the purpose and general goals of the research]**. You are being invited to participate in this research study because **[insert qualification for participation]**.

### What will I be asked to do in the study?

If you take part in this study, you will be asked to

**[insert a detailed description of the study activities in layman's terms.]**

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- **Include any behavioral interventions, tests, surveys, along with the frequency and general nature of the instrument.**
- **Distinguish between activities that may represent usual practice of daily living from those that are strictly research.]**

### What are the possible risks or discomforts?

Participation in this study may involve some added risks or discomforts. These may include those directly related to study procedures as well as uneasiness related to the subject of this study. You may contact the study doctor if you are concerned about anything during the course of your participation in this study.

The risks and/or discomforts include the following:

***List only the risks and/or discomforts related to the investigational aspects of the study.***

***Example 1:*** You will be asked questions about your comfort with current world events and global cooperation. Some of these questions could make you feel uncomfortable. The research team will help you gain access to a trained person for you to discuss your feelings.

***Example 2:*** You will be asked to monitor your blood glucose several times daily and keep a diary of your exercise. It is possible that this activity may be more than your usual activity and you may experience soreness. You should discuss any concerns about discomfort with the research personnel.

#### **Loss of Confidentiality:**

Any time information is collected; there is a potential risk for loss of confidentiality. Every effort will be made to keep your information confidential; however, this cannot be guaranteed.

#### **Other risks:**

*[Include the possibility of risks that are not known or discomforts that cannot reasonably be anticipated.]*

### What if new information becomes available?

You will be told about new information that may affect your well-being, safety, health, or willingness to stay in the study.

### What are the possible benefits of the study?

***[Choose an appropriate choice for the study]***

- *There is no benefit from your participation in this study*
- *You may benefit from participation in this study [insert benefit: e.g. You may benefit from participation in this study by gaining an understanding about your fears.]*
- *There may be not benefit from your participation in this study, but there may be a benefit to society through an increased understanding about [insert benefit: e.g.*

*We may benefit society overall by increasing our understanding of situations that lead to PTSD.]*

## What other choices do I have if I do not participate?

**Taking part in this study is voluntary.** You may choose not to take part in the study or may choose to leave the study at any time. ***[insert relevant information about voluntary participation, such as: you may skip over any questions that you find uncomfortable.]*** Deciding not to participate, or deciding to leave the study later, will not result in any penalty or loss of benefits to which you are entitled, and will not affect your relationship with **[Insert appropriate entity (e.g., hospital, university)]**.

## Will I have to pay for anything?

***[Modify this section to fit the protocol.]*** There will be no costs to you for participating in this research study.

If there are procedures and/or tests that are part of the research that would have been done as part of your healthcare, these procedures will be billed to your insurance carrier as standard of care.

While you participate in this study, you may have costs which include such things as transportation, child care, time from work, if you are employed that are not reimbursed.

- *List the additional tests/visits/procedures to be performed for research purposes only. Describe who will be responsible for paying the cost of research tests, procedures, visits, etc. that are not standard of care.*
- *Clearly explain what the likely costs will be for participation in this research study and who will be responsible for those costs e.g. "... billed to you and/or your insurance." Or "... paid by the sponsor.*
- *Describe specific items or procedures that may/may not be covered. Include clinic fees, transportation, and parking fees (if known).*

***[The following section is open for modification by participating sites:]***

## What happens if I am injured from being in the study?

*[Instruction to PI: Include any language that may be applicable depending on the sponsor of the study, e.g., If as part of participating in the study, you are injured by the study drug or study-related procedures done to you in accordance with the study protocol, **[insert sponsor name]** will pay for reasonable and necessary medical expenses to treat the injury. , **[insert sponsor name]** is not offering to compensate you for any other expenses, but you do not waive any legal rights you may have to seek compensation by signing this consent form.]*

The **[insert Medical Center]** does not plan to pay for medical care that you may have as a result of taking part in this study. However, you do not give up any rights you may have to seek compensation by signing this form.

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For questions about the study or in the event of a research-related injury, contact [insert name of the study investigator, Name at telephone number (also include after-hours number).

### When is the study over? Can I leave the Study before it ends?

If you first agree to participate and then you change your mind, you are free to withdraw your consent and discontinue your participation at any time. Your decision will not affect your ability to receive medical care and you will not lose any benefits to which you would otherwise be entitled.

If you decide to withdraw your consent to participate in this study, you should notify (**insert name of principal investigator**) at (telephone number). *Clearly outline the study withdrawal procedures (Suggestion: check your protocol).*

**[If appropriate to the study]** If you withdraw from the study for any reason,

- *add anticipated consequences, if any, of discontinuing participation*
- *Clearly state the protocol-specific termination procedures.*
- *Instruct participants that they must return all study-related supplies (if any).*

The Principal Investigator may also withdraw you from the study *and the study medication may be stopped [if applicable]*, without your consent for one or more of the following reasons

- Failure to follow the instructions of the Principal Investigator and study staff.
- The Principal investigator decides that continuing your participation could be harmful to you.
- Pregnancy **[Delete if not relevant]**
- The study is cancelled.
- Other administrative reasons.
- Unanticipated circumstances.

If you choose not to participate, are not eligible to participate, or withdraw from this research study, this will not affect your present or future care and will not cause any penalty or loss of benefits to which you are otherwise entitled.

It is important to tell the research doctor if you are thinking about stopping so your research doctor can evaluate the risks from stopping. Another reason to tell your research doctor that you are thinking about stopping is to discuss what follow-up care and testing could be most helpful for you.

You may be taken out of the study if it is felt that staying in the study would be harmful to you, if you need treatment not allowed in the study, if you do not follow instructions, if you become pregnant or if the study is cancelled. If you are withdrawn from the study, the reason will be explained to you.

**[The following section is open for modification by participating sites:]**

## **If I take part in this research study, how will you protect my privacy?**

Your privacy is very important to us. The study doctors will make every effort to protect it.

This study has support from the National Institutes of Health (NIH) and your study information is protected by a Certificate of Confidentiality. This certificate allows us, in some cases, to refuse to give out your information even if requested using legal means.

It does not protect information that we must report by law, such as child abuse or some infectious diseases. The Certificate does not prevent us from disclosing your information if we learn of possible harm to yourself or others, or if you need medical help. Disclosures that you consent to in this document are not protected. This includes putting research data in the medical record or sharing research data for this study or future research. Disclosures that you make yourself are also not protected.

During this research, identifiable information about your health will be collected. In the rest of this section, we refer to this information simply as “health information.” In general, under federal law, health information is private. However, there are exceptions to this rule, and you should know who may be able to see, use, and share your health information for research and why they may need to do so.

In this study, we may collect health information about you from:

- Past, present, and future medical records
- Research procedures, including research office visits, tests, interviews, and questionnaires

Who may see, use, and share your identifiable health information and why they may need to do so:

- The research staff involved in this study
- The sponsor(s) of this study, and the people or groups it hires to help perform this research
- Other researchers and medical centers that are part of this study and their ethics boards
- A group that oversees the data (study information) and safety of this research
- Non-research staff who need this information to do their jobs (such as for treatment, payment (billing), or health care operations)
- The IRB that oversees the research and the research quality improvement programs.
- People from organizations that provide independent accreditation and oversight of hospitals and research
- People or groups that we hire to do work for us, such as data storage companies, insurers, and lawyers
- Federal and state agencies (such as the Food and Drug Administration, the Department of Health and Human Services, the National Institutes of Health, and other US or foreign government bodies that oversee or review research)
- Public health and safety authorities (for example, if we learn information that could mean harm to you or others, we may need to report this, as required by law)
- Other

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Some people or groups who get your health information might not have to follow the same privacy rules that we follow and might use or share your health information without your permission in ways that are not described in this form. For example, we understand that the sponsor of this study may use your health information to perform additional research on various products or conditions, to obtain regulatory approval of its products, to propose new products, and to oversee and improve its products' performance. We share your health information only when we must, and we ask anyone who receives it from us to take measures to protect your privacy. The sponsor has agreed that it will not contact you without your permission and will not use or share your information for any mailing or marketing list. However, once your information is shared outside this institution, we cannot control all the ways that others use or share it and cannot promise that it will remain private.

Because research is an ongoing process, we cannot give you an exact date when we will either destroy or stop using or sharing your health information.

The results of this research study may be published in a medical book or journal or used to teach others. However, your name or other identifying information **will not** be used for these purposes without your specific permission.]

**[The following section is open for modification by participating sites:]**

### **What are your Rights?**

You have the right not to sign this form that allows us to use and share your health information for research; however, if you don't sign it, you can't take part in this research study.

You have the right to withdraw your permission for us to use or share your health information for this research study. If you want to withdraw your permission, you must notify the person in charge of this research study in writing. Once permission is withdrawn, you cannot continue to take part in the study.

If you withdraw your permission, we will not be able to take back information that has already been used or shared with others.

You have the right to see and get a copy of your health information that is used or shared for treatment or for payment. To ask for this information, please contact the person in charge of this research study. You may only get such information after the research is finished. ]

### **How does the Institutional Review Board (IRB) protect you?**

The Institutional Review Board (IRB) reviews all human participant research before it can be implemented and then regularly as long as there is any research activity. The primary concern of the IRB is for the protection of human participants participating in research. For questions about your rights as a research participant, contact the [insert institution name] Institutional Review Board (IRB) Office at [insert phone number / e-mail address].

### **Who can I call with questions, or if I'm concerned about my rights as a research participant?**

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- You can call the IRB with your questions or concerns. Our telephone numbers are listed below. Ask questions as often as you want. [Insert name and academic degrees] is the person in charge of this research study. If you want to speak with someone not directly involved in this research study, please contact [insert name of contact or IRB]. You can call them at [insert contact information].
  - You can talk to them about:
  - Your rights as a research participant
  - Your concerns about the research
  - A complaint about the research Also, if you feel pressured to take part in this research study, or to continue with it, they want to know and can help.

*[Add this paragraphs for studies requiring registration with [ClinicalTrials.gov](http://www.ClinicalTrials.gov)]*

A description of this clinical trial will be available on <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.

**When you sign this form**, you are agreeing to take part in this research study as described to you. This means that you have read the consent form, your questions have been answered, and you have decided to volunteer.

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Name of Participant (Print)

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Signature of Participant

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Date

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Name of Person Obtaining Consent  
(Print)

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Signature of Person Obtaining  
Consent

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Date

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***[The following sections provide signature blocks necessary for other types of research including:***

- Studies where it is necessary to use an authorized participant representative*
- Pediatrics studies – for parental consent*
- Studies using the short form consent process*
- Studies involving participants who cannot read*

*Select or delete a given section and it's signature block as applicable for your specific study.]*

***[For studies using authorized participant representatives:***

*Use the authorization signature line only for studies that are approved by the IRB to permit participant representatives to authorize a participant's participation in research. Delete if not applicable.]*

For participants unable to give consent, the consent for study participation and authorization to collect and use protected health information is given by the following authorized participant representative:

<hr/> Name of Authorized Participant Representative (Print)	<hr/> Signature of Authorized Participant Representative	<hr/> Date
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Select the category that best describes the above Authorized Participant Representative:

- ☐ Court-appointed guardian
- ☐ Health care proxy
- ☐ Durable power of attorney
- ☐ Family member/next of kin; for this category describe relationship below:

***[For pediatric studies (note: certain studies require the signature of both parents. If the IRB determines this is required, add another signature block for the other parent.)]***

**Signature of Parent(s)/Guardian for Child**

I give my consent for my child to take part in this research study and agree to allow his/her health information to be used and shared as described above.

<hr/> Name of Parent (Print)	<hr/> Signature of Parent	<hr/> Date
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**[The following section is open for modification by participating sites:]**

## **[Genetic Screening “Rider” for Consent Forms]**

### **Consent for Genetic Research**

The purpose of this study is to look at genes (DNA) and how they affect health and disease. Genes are the instruction manual for your body. The genes you get from your parents decide what you look like and how your body behaves. They can also tell us a person’s risk for certain diseases and how they will respond to treatment.

You are being asked to give a *[Insert type of sample, e.g. blood, urine, etc.]* for genetic research. What we learn about you from this sample *(will not be)* or *(may be)* put in your health record. *[If applicable insert:* Your test results will not be shared with you or your doctor. No one else (like a relative, boss, or insurance company) will be given your test results.]

A single *[blood sample of X teaspoons or tablespoons will be drawn from a vein in your arm using a needle; cheek swab sample will be obtained by (indicate method); urine sample will be obtained by (indicate method); extra biopsy tissue will be obtained by (indicate method); or other (indicate what) sample will be obtained by (indicate method.)]* This will take about X minutes/hour of your time.

*If applicable insert:*

**Blood samples** – You may feel bothered or pained from the needle stick. You may have a bruise or the site may get infected. It is rare, but some people faint.

*Otherwise insert all risks, inconveniences or discomforts associated with specific type of sample collection*

*[Insert if true, this may not be applicable for personalized medicine testing:]* One risk of giving samples for this research may be the release of your name that could link you to the stored samples and/or the results of the tests run on your samples. This may cause problems with insurance or getting a job.

To prevent this, these samples will be given a code. Only the study staff will know the code. The name that belongs to the code will be kept in a locked file or in a computer with a password. Only *(investigator’s name and/or other’s names)* will have access to your name.

Health insurance companies and group health plans may not use your genetic information when making decisions regarding your eligibility or premiums. Employers with 15 or more employees may not use your genetic information that comes from this research when making a decision to hire, promote, or fire you or when setting the terms of your employment.

Your sample will be used to make DNA that will be kept for an unknown length of time (maybe years) for future research. The sample will be destroyed when it is no longer needed.

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**[COMMERCIALIZATION LANGUAGE OPTION — INSERT THE FOLLOWING, IF APPLICABLE]:**

Your samples may be used to make new products, tests or findings. These may have value and may be developed and owned by the study staff, [institution], and/or others. If this happens, there are no plans to provide money to you.

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**[INSERT THE FOLLOWING STATEMENT IF TRUE]:**

Your samples and information about you may be shared with others to use for research. To protect your privacy, we will not release your name.

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You will not receive any benefit as a result of the tests done on your samples. These tests may help us learn more about the causes, risks, treatments, or how to prevent this and other health problems.

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**[Insert if genetic portion is optional]**

Giving samples for research is your free choice and you may be in the study even if you do not want your samples used or stored for gene research.

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At any time, you may ask to have your sample destroyed. You should contact [PI name or study staff] at [insert address/phone number] to have your sample destroyed and no longer used for research. We will not be able to destroy research data that has already been gathered using your sample. Also, if your identity was removed from the samples, we will not be able to locate and destroy them.

There will be no costs to you for any of the tests done on your samples. [Insert if applicable: You will not be paid for the use of your samples.]

Please check Yes or No to the questions below:

My blood/tissue sample may be used for gene research in this study.

☐ Yes      ☐ No

My blood/tissue sample may be stored/shared for future gene research in \_\_\_\_\_.

☐ Yes      ☐ No

My blood/tissue sample may be stored/shared for future gene research for other health problems (such as cancer, heart disease, etc.).

☐ Yes      ☐ No

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Signature: \_\_\_\_\_ Date: \_\_\_\_\_ ]