PARTICIPANT INFORMED CONSENT FORM (PICF)

Protocol / Study number: _____

Participant identification number for this study: _____

Title of Study:

Principal Investigator:

The contents of the information sheet that was provided have been read carefully by me / explained in detail to me, in a language that I comprehend, and I have fully understood the contents. I confirm that I have had the opportunity to ask questions. The nature and purpose of the study and its potential risks / benefits and expected duration of the study, and other relevant details of the study have been explained to me in detail. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal right being affected.

I understand that the information collected about me from my participation in this research and sections of any of my medical notes may be looked at by responsible individuals from ACBR. I give permission for these individuals to have access to my records.

I agree to take part in the above study.

---------- Date:

(Signatures / Left Thumb Impression) Place:

Name of the Participant: _____

Son / Daughter / Spouse of:_____

Complete postal address: _____

This is to certify that the above consent has been obtained in my presence.

Signatures of the Principal Investigator

Date:

Place:

1) Witness – 1

2) Witness – 2

Signatures

Name:

Address:

Signatures

Name:

Address: