**Study Title**: *insert study title as written on the protocol*

SIGNATURES

* All my questions have been answered,
* I understand the information within this informed consent form,
* I allow access to medical records and transfer of specimens and related personal health information as explained in this consent form,
* I do not give up any of my legal rights by signing this consent form,
* I understand that my family doctor/health care provider will/may be informed of study participation,
* I agree, or agree to allow the person I am responsible for, to take part in this study.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Signature of Participant /Substitute Decision-Maker |  | Printed Name |  | Date |

If consent is provided \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

by Substitute Decision Maker: PRINTED NAME of Participant

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Signature of Person Conducting the Consent Discussion |  | Printed Name and Role |  | Date |

IMPARTIAL WITNESS:

* The study was explained to the participant
* The participant had the opportunity to ask questions and any questions were answered
* The participant appeared to understand the information that was provided
* The participant voluntarily agreed to participate in the study

Relationship to Participant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Impartial Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of the Impartial Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* If the impartial witness is unable to sign, please explain. If the impartial witness is staff, please indicate where the impartial witness has documented that a consent process took place. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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