ALL INDIA INSTITUTE OF MEDICAL SCIENCES, RAJKOT (GUJARAT)

INFORMED CONSENT FORM

Title of the project :

Name of the Principal Investigator :

Designation and contact number of PI :

Patient/Volunteer Identification No. :

I,……..S/o or D/o…… R/o……give my full, free, voluntary consent to be a part of the entitled study. The procedure and nature of which has been explained to me in my own language to my full satisfaction. I confirm that I have had the opportunity to ask questions.

I understand that my participation is voluntary and am aware of my right to opt out of the study at any time without giving any reason.

I understand that the information collected about me and any of my medical records may be looked at by responsible individual from……..(Institute Name) or from regulatory authorities. I give permission for these individuals to have access to my records.

Date: Place:

Signature/Left thumb impression:

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

Date: Place:

Signature/Left thumb impression:

Witness 1

Signature:

Name:

Address:

Witness 2

Signature:

Name:

Address: