RAM MANOHAR LOHIA INSTITUTE OF MEDICAL SCIENCES, LUCKNOW

INFORMED CONSENT FORM

Study Title____
Study Number____
Subject's Full Name____
Date of Birth/Age____
Address____

Name of Principal Investigator   Contact No.

1. I confirm that I have read and understood the information sheets dated______ for the above study and have the opportunity to ask questions.

   OR I have been explained the nature of the study by the Investigator and had the opportunity to ask questions.

2. I understand that my participation in the study is voluntary and that I am free to withdraw at any time, without giving any reason and without my medicine care or legal rights being affected.
3. I understand that the sponsor of the clinical trial/ project, others working on the Sponsor's behalf, the Ethics Committee and the regulatory authorities will not need my permission to look at my health records both in respect of the current study and my further research that may be conduct in relation to it, ever if I withdraw from the trial. However, I understand that my Identity will not be revealed in any information released to third parties or published. I will not be entitled for any compensation.
4. I agree not to restrict the use of any data or result that arises from this study [provided such a use is only for scientific purpose(s)
5. I agree to take in the above study

Signature (or Thumb impression) of the Subject/Legally Acceptable Representative e:__________________

Signatory's Name__________________   Date_______________

Signature of the Investigator_______________   Date_______________

Study Investigator's Name__________________

Signature of Witness___________________________   Date_______________

Name of Witness______________________________