

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. The entire methodology/process of the study has been completely read over and/or clearly explained to me including the risks involved if any. I have completely understood the same and hereby giving my consent with free will.

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_____