COSTS OF PARTICIPATION

If you take part in this study, the following will be performed at no charge to you: *(Insert list of procedures / drugs/ tests for which the subject will NOT pay).*You will not receive any compensation for participating in this study.

RESEARCH RELATED INJURY AND COMPENSATION

The Hospital does not make any provisions to compensate trial subjects for research related injury. However, you would be treated for the same at no additional costs at this hospital.

WHO TO CONTACT IF YOU HAVE QUESTIONS

If you have questions about this research study and your rights or in the case of any injuries during the course of this study, you may contact the Principal Investigator *(Insert Name and contact Details including place and phone numbers here).*

CONSENT BY RESEARCH SUBJECT	
Details of Research Study	
Protocol Title: *Use the full protocol title as used in the IRB Application*	
Principal Investigator: *Include full name, address and phone number*	
Subject's Particulars	
Name:	NRIC No.:
Address:	
Sex: Female/Male	Date of birth _____ dd/mm/yyyy
Race: Chinese/ Malay/ Indian /Others (please specify) _____	
Part I – to be filled by patient	

I, _____(NRIC/Passport No._____)

(Name of patient)

agree / do not agree to participate in the research study as described and on the terms set out in the Patient Information Sheet. The nature of my participation in the proposed research study has been explained to me in

_____ by Dr/Mr/Ms _____

(Language / Dialect) (Name of healthcare worker)

I have fully discussed and understood the purpose and procedures of this study. I have been given the Patient Information Sheet and the opportunity to ask questions about this study and have received satisfactory answers and information.

I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reasons and without my medical care being affected.

I also give permission for information in my medical records to be used for research. In any event of publication, I understand that this information will not bear my name or other identifiers and that due care will be taken to preserve the confidentiality of this information.

_____ _____

[Signature/Thumbprint (Right / Left) of patient] (Date of signing)

Part II – to be filled by parent / legal guardian, where applicable

I, _____ hereby give consent for the above patient to participate in the (parent / legal guardian)
proposed research study. The nature, risks and benefits of the study have been explained clearly to me and I fully understand them.

_____ _____
[Signature/Thumbprint (Right / Left) of parent /legal guardian] (Date of signing)

Part III – to be filled witness, where applicable

An impartial witness should be present during the entire informed consent discussion if a subject or the subject's legally acceptable representative is unable to read. After the written informed consent form and any written information to be provided to subjects, is read and explained to the subject or the subject's legally acceptable representative, and after the subject or the subject's legally representative has orally consented to the subject's participation in the study and, if capable of doing so, has signed and personally dated the consent form, the witness should sign and personally date the consent form.

Witnessed by: _____ _____
(Name of witness) (Designation of witness)

_____
_____
(Signature of witness) (Date of signing)

Part IV– Investigator's Statement

I, the undersigned, certify to the best of my knowledge that the patient/patient's legally acceptable representative signing this informed consent form had the study fully explained and clearly understands the nature, risks and benefits of his/her / his ward's / her ward's participation in the study.

_____ _____ _____
Name of Investigator Signature
Date