

# Clinical Trial Consent Form

Title of Study:

Protocol Number:

Principal Investigator:

Institution/Organization:

## Participant Information

Participant Name:

Date of Birth:

Contact Information:

## Purpose of the Study

## Procedures

## Risks and Discomforts

**Benefits**

**Confidentiality**

**Voluntary Participation and Withdrawal**

**Contact Information for Questions**

Name:

Phone/Email:

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**Consent**

I have read (or have had read to me) the information provided above. I have had the opportunity to ask questions about the study and all my questions have been answered to my satisfaction. I voluntarily agree to participate in this study.

Participant Signature:

Date:

Printed Name:

Researcher/Witness Signature:

Date: