THE UNIVERSITY OF THE WEST INDIES
ST. AUGUSTINE, TRINIDAD AND TOBAGO, WEST INDIES
CAMPUS ETHICS COMMITTEE

CONSENT TO PARTICIPATE IN RESEARCH

Phone: 645-3232 Ext: 5021 Email: campusethics@sta.uwi.edu

Complete Protocol Title

Principal Investigator

Co-Investigators

Research Site(s)

Sponsors

Why is this research being done?

What is the duration of taking part in the study (for each subject)?

What will happen to me?

What is in in for me?

What will happen if I drop out of the study early?

What are my responsibilities if I join and what about confidentiality?

What if I get hurt in the study?

CONSENT

I have read and understood this explanation. The researcher has also explained the study to me. I have had a chance to ask questions and have them answered to my satisfaction. I agree to take part in this study. I have not been forced or made to feel like I had to take part.

I have read the attached experimental Subject's Rights, which contain some important information about research studies. I have also read the Authorisation to use my Private Health Information. **I must sign this Consent Form, the Experimental Subject's Rights and the Authorisation to use my Private Health Information. I will be given a signed copy of each to keep.**

Print Name of Subject | Signature of Subject | Date

Signature of Person conducting the informed consent discussion | Date

Role of person named above in the research project

Signature of Second Witness | Date

This document was approved by Campus Ethics Committee on: | **By Chairman:**

This document expires on:

EXPERIMENTAL SUBJECT'S RIGHTS

If I am asked to consent to participate as a subject in a research study involving a medical experiment, or if I am asked to consent for someone else, I have the right to:

1. *Learn the nature and purpose of the experiment (also called "study" or "clinical trial").*
2. *Receive an explanation of the procedures to be followed in the study, and any drug or device used.*
3. *Receive a description of any discomforts and risks that I could experience from the study.*
4. *Receive an explanation of any benefits I might expect form the study.*
5. *Learn about the risks and benefits of any other available procedures, drugs or devices that might be helpful to me.*
6. *Learn what medical treatment will be made available to me if I should be injured as a result of this study.*
7. *Ask any questions about the study or the procedures involved.*
8. *Quit the study at any time, and my decision will not be used as an excuse to withhold necessary medical treatment.*
9. *Receive a copy of the signed and dated consent form.*
10. *Decide to consent or not to consent to a study without feeling forced or obligated.*

If I have questions about a research study, I can call the contact person listed on the consent form. If I have concerns about the research staff, or need more information about my rights as a subject, I can contact the Principal Investigator, The University of the West Indies at:

By signing this document, I agree that I have ready and received a copy of this document.

Signature of Subject or Legal Representative **Date**

REQUEST FOR PERMISSION TO USE AN INDIVIDUAL'S PRIVATE HEALTH INFORMATION

Name of Study:

Investigators:

What is private health information?

Private health information is any information that can be traced back to you. We need your permission to use your private health information in this research study. The type of private health information that will be used and shared for this study includes:
- Your past and present physical and mental health information
- Information that can be used to contact you
- Results of your medical tests and DNA
- Questionnaires and information on your drug/alcohol usage and that of your family.

Who else will see my information?

How long will the investigators use and share my information?

What if I change my mind about sharing my research information?

Do I have the right to see and copy my research information?

If you agree to share your information, you should sign this form below. You will receive a copy of this form.

I agree to share my information as described in this form

Print Name **Signature** **Date**

If you have questions or concerns about your privacy and the use of your personal medical information, please contact the investigator at the telephone number listed in the consent form.