**DOCUMENTATION OF PHYSICIAN CONSENT**

|  |  |  |
| --- | --- | --- |
| Study Number | Study Title | Principal Investigator |
|  |  |  |

**My signature below indicates that I have discussed the risks, benefits, and alternatives, answered any questions, and believe the participant is able to make an informed choice to join the study.**

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Signature of Physician/Mid-Level Provider (Print Name) Date/Time

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Participant (Print Name) Date/Time

**Add any of the following that are applicable for this study and delete any that do not apply**

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Signature of Legally Authorized Representative (LAR) (Print Name) Date/Time

**For ADULTS NOT CAPABLE of GIVING CONSENT** (*Persons from* *the following categories in order of*

*priority may be a Legally Authorized Representative: Health Care Agent; Legal Guardian;*

*Spouse; Adult child; Parent; Adult sibling; Friend or other relative)*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship of LAR to Participant (indicate why the LAR is authorized Date/Time

to act as a surrogate health care decision-maker under state or applicable local law)

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Signature of Parent (Print Name) Date/Time

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Signature of Legally Authorized Representative (LAR) (Print Name) Date/Time

for CHILD PARTICIPANT

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Description of LAR’s authority under state or applicable local law to act as surrogate health care Date/Time decision-maker for child research participant (for example, Legal Guardian, court-ordered representative)

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(required if DHHS 45 CFR 46.406 or 46.407/FDA 21 CFR 50.53 or 50.54 study)

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Signature of Child Participant (optional unless IRB required) (Print Name) Date/Time

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Signature of Witness to Consent Procedures (Print Name) Date/Time

(optional unless IRB or Sponsor required)