### The UNIVERSITY OF CHICAGO

### The Division of the Biological Sciences • The University of Chicago Medical Center

**CONSENT/AUTHORIZATION FOR PARTICIPATION IN A RESEARCH PROTOCOL**

***(****remove “Authorization” if the form is not a HIPAA authorization)*

Protocol Number: *[insert #]* Name of Subject: Medical History Number:

## STUDY TITLE: *(insert study title)*

Doctors Directing Research: *[include PI & at least 1 other investigator]*

Address: *(insert complete mailing address, including mail code if applicable)*

Telephone Number: *(insert complete telephone number)*

**KEY INFORMATION**

We are inviting you to take part in a research study about *[Insert Description of Study]*. Healthy individuals over \_\_ years of age who *[Insert eligibility criteria, for example, “are moderate drinkers”]* may participate.

**WHAT IS THE STUDY ABOUT AND HOW LONG WILL IT LAST?**

By doing this study, we are trying to see how *[describe purpose of study in simple language]*. We hope to learn how *[describe aims in simple language, for example: how smoking impacts women’s health*] . If you enroll in the study, you will participate in X number of visits, each lasting X number of hours. During these visits, you will be asked to do things such as *[insert tasks, examples: complete a survey, participate in a focus group, etc.]* A list of all tasks to be completed and a schedule of these tasks are included in the detailed consent.

**WHAT ARE REASONS YOU MIGHT CHOOSE TO VOLUNTEER FOR THIS STUDY?**

Your participation in this study may not directly benefit you. However, by participating you will be helping us better understand how insert objectives of the study.

**WHAT ARE REASONS YOU MIGHT CHOOSE NOT TO VOLUNTEER FOR THIS STUDY?**

To the best of our knowledge, the things you will be doing have no more risk of harm than you would experience in everyday life. However, if the study tasks cause you to feel emotional distress, you may stop participating. In addition, if you have *[insert exclusion criteria here (such as epilepsy, pregnancy, claustrophobia for a MRI study)]* , you should not participate in this research.

**WILL I BE PAID?**

If you complete the study, you will be paid list payment schedule here.

**DO YOU HAVE TO TAKE PART IN THE STUDY?**

If you decide to take part in the study, it should be because you really want to volunteer. You will not lose any services, benefits or rights you would normally have if you choose not to volunteer.

**WHAT IF YOU HAVE QUESTIONS, SUGGESTIONS OR CONCERNS?**

The person in charge of the study is *[Principal Investigator, PI]* of the University of Chicago. If you have questions, suggestions, or concerns regarding this study or you want to withdraw from the study his/her contact information is: *[PI contact information].*

*[If the study does not involve ANY physical intervention, this paragraph may be removed.]*

If you have a research related injury, you should immediately contact*(insert name and phone # –the number listed in this section should provide access to someone 24 hours a day, 7 days a week).*

For questions about your rights as a research subject, please contact the University of Chicago BSD Institutional Review Board (IRB) at 773-702-6505.