Sample Consent Form

Consent Form for Participation in the Research Study Entitled

Title

Principal Investigator:

Complete mailing address:

Contact Phone Number:

Co –Investigator(s):

Complete Mailing Address:

Contact Phone Number:

What is this study about?
This study involves taking blood pressures on adults. The purpose of the study is to see if five rapid blood pressure cuff re-inflations change individual blood pressure readings.

Why are you asking me?
You are being asked to be in this study because adults over age 65 are the subjects.

What will I be doing if I agree to be in the study?
You will view a short video explaining the study; and will answer a series of questions to screen for health issues that may affect blood pressure values. Following this, you will be taken to a quiet room to rest for 5 minutes. Then a blood pressure cuff will be placed on your right arm with five blood pressures taken in rapid succession. Only the investigators will be able to see blood pressure readings and the cuff will be deflated after each measure. Before leaving the testing area, you will be cleared by one of the investigators should any study-related symptoms appear (i.e., dizziness, etc.) Total study time in the testing room should be no more than 30 minutes.

What are the dangers to me?
Study dangers are small and include: 1) arm "squeezing" when the cuff fills with air, 2) brief arm redness just after the cuff is taken off, and 3) brief dizziness. All studies are thought to have some risk. Although unlikely, the procedures or activities in this study may have unknown or unforeseeable risks.

If you have any questions about the research, your research rights, or have a research-related injury, please contact Dr. (principal investigator name here), principal investigator at (phone # here). You may also contact the Institutional Review Board at irb@franklinpierce.edu with questions as to your research rights.

Are there any benefits or compensation for taking part in this research study?
There are no direct benefits. You will not receive any compensation for participating in this study.

Will I get paid for being in the study? Will it cost me anything?
There are no costs to you or payments made for participating in this study.

How will you keep my information private?
Your information will be kept in a locked file cabinet in (principal investigator) campus office for a period of 36 months from the conclusion of the study. Only (principal investigator or researchers) will have the key and access to this file cabinet. All information obtained in this study is strictly confidential unless disclosure is required by law. Further, the IRB and associated regulatory agencies may review research records.

What if I do not want to participate or I want to leave the study?
You have the right to leave this study at any time or refuse to participate. If you do decide to leave or you decide not to participate, you will not experience any penalty or loss of services you have a right to receive. If you choose to withdraw, any information collected about you **before** the date you leave the study will be kept in the research records for 36 months from the conclusion of the study and may be used as a part of the research.

Voluntary Consent by Participant
By signing below, you indicate that

- This study has been explained to you
- You are over 18 years of age
- You have read this document or it has been read to you
- Your questions about this research study have been answered
- You have been told that you may ask the researchers any study related questions in the future or contact them in the event of a research-related injury
- You have been told that you may ask Institutional Review Board (IRB) personnel questions about your study rights
- You will not receive any benefit or compensation for your participation
- You are entitled to a copy of this form after you have read and signed it
- You voluntarily agree to participate in the study entitled **(study title here)**

Participant's Signature: _____ Date: _____

Participant's Printed Name: _____ Date: _____

Signature of Person Obtaining Consent: _____

Date: _____