**Short form for persons who do not read English**

Name of study: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I have been asked to take part in a research study. The study doctor or nurse has told me the following things about the study**:**

 why the study is being done

 what will happen to me if I am in the study (exams, tests, treatments, etc.)

 how long I will be in the study

 what parts, if any, are experimental

 the possible risks, discomforts, and benefits of the study (there is always a chance that I might have a side effect of a test or treatment that we didn’t know about before)

 alternatives to being in the study

 how my study records will be kept private

 how I can receive medical care if I am hurt in the study and whether I will have to pay for it

 whether the study will cost me anything

 the situations in which the study doctor could take me out of the study

 what happens if I decide to stop being in the study

 how I will be told about any new information about the study, especially if this information might affect my decision to be in the study

 how many people will be in the study.

## Who to call with questions or concerns

I may contact Dr. \_\_\_\_\_\_\_\_\_\_\_\_ at \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ at any time if I have

questions about the research or if I think I have been hurt by the research.

I may contact the office of the IRBMED at 734-763-4768 if I have questions about my rights as a research subject.

Signing this form means that the research study has been described to me orally, in language I understand. If I agree to be in the study, I willbe given a signed copy of this form and a written summary of the study. I will have a chance to ask questions about the study**.**  These questions should be answered to my satisfaction before I sign this form. I may choose not to be in the study or I may quit being in the study at any time without loss of any privileges to which I am entitled.

I know what will be done as part of this study. I also know the possible good and bad (benefits and risks) that could happen if I am in this study. I choose to be in this study**.** I know I can stop being in the study at any time, and I will still get the usual medical care.

Signature of Participant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_

Signature of Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_

Signature of Interpreter: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_ \_\_ / \_\_ \_\_ / \_\_ \_\_