**Consent Form for Participation in a Research Study**

**Title of Study (use same title as submitted to IRB)**

**Description of the research and your participation**

You are invited to participate in a research study conducted by **(insert the name of the Principal Investigator here).** The purpose of this research is **(explain using language which can be easily understood by the subject).**

Your participation will involve **(describe the procedures to be followed).**

**Risks and discomforts**

There are no known risks associated with this research. **OR**

There are certain risks or discomforts associated with this research. They include **(describe any reasonably foreseeable risks or discomforts to the participant. You may also describe the measures you will take to minimize these risks and discomforts.)**

**Potential benefits**

There are no known benefits to you that would result from your participation in this research. OR

**(Describe any benefits to the participant and to others that may reasonably be expected from the research.)**

This research may help us to understand **(brief statement, if appropriate).**

**Protection of confidentiality**

**(Describe the extent to which confidentiality of records identifying the participant will be maintained.**

**If appropriate, precede the description with**:

We will do everything we can to protect your privacy.

**If appropriate, follow the description with:**

Your identity will not be revealed in any publication resulting from this study.

**Voluntary participation**

Your participation in this research study is voluntary. You may choose not to participate and you may withdraw your consent to participate at any time. You will not be penalized in any way should you decide not to participate or to withdraw from this study.

**Contact information**

If you have any questions or concerns about this study or if any problems arise, please contact **(insert Principal Investigator’s name here)** at **(location name) at XXX-XXX-XXXX.** If you have any questions or concerns about your rights as a research participant, please contact the CHRISTUS Health IRB at 469-282-2686 or via email at christus.irb@christushealth.org.

A copy of this consent form will be given to you.

**Consent**

**I have read this consent form and have been given the opportunity to ask questions. I give my consent to participate in this study.**

Participant’s signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Person Obtaining Consent**

I have discussed this clinical research study with the participant and/or his or her authorized representative, using language that is understandable and appropriate. I believe that I have fully informed this participant of the nature of this study and its possible benefits and risks and that the participant understood this explanation.

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**Signature of Principal Investigator Printed Name Date**

**Or Person Obtaining Consent**

[ ]  Yes [ ]  No **Are you a CHRISTUS Health or CHRISTUS Health Affiliate employee?**

You will receive a signed and dated copy of the Voluntary Participation in a Clinical Research Study by a CHRISTUS Health or CHRISTUS Health Affiliate Employee form for your records.