Informed Medical Consent Form

This **informed medical consent form** is designed to ensure that participants in a clinical trial fully understand the study, its purpose, procedures, risks, and benefits. Please read this form carefully and ask any questions you may have before agreeing to participate.

Study Title

[Insert the full title of the clinical trial]

Principal Investigator

Name: _____
Contact Information: _____

Purpose of the Study

[Describe the purpose and goal of the clinical trial in clear, simple language]

Procedures

- *[Describe procedures, tests, treatments, and duration of participant involvement]*
- *[State location and frequency of study visits]*

Risks and Discomforts

- *[List possible risks, side effects, and discomforts associated with participation]*
- *[Mention unforeseeable risks, if applicable]*

Benefits

- *[Describe any potential benefits to the participant or others]*
- *[Clarify if there may be no direct benefit]*

Alternatives

[List alternative treatments or procedures available to the participant]

Confidentiality

All information collected in this study will be kept strictly confidential. Results may be published but will not include any personal identifying information.

Voluntary Participation & Right to Withdraw

Your participation is completely voluntary. You may refuse to take part or withdraw from the study at any time without affecting your medical care or any benefits to which you are entitled.

Contact for Questions

If you have any questions about this study or your rights as a participant, please contact:
Name: _____
Phone: _____
Email: _____

Consent Statement

By signing below, I confirm that I have read (or had read to me) this consent form, had my questions answered, and voluntarily agree to participate in this clinical trial.

Participant Name (printed): _____

Participant Signature: _____

Date: _____

Witness Name (printed): _____

Witness Signature: _____

Date: _____