LOYOLA UNIVERSITY CHICAGO
HEALTH SCIENCES DIVISION
MAYWOOD, ILLINOIS

CONSENT TO PARTICIPATE IN RESEARCH
Short Form Written Consent Document for Non-English Speaking Participants

Participant's Name: _____

Medical Record Number: _____

Protocol IRB#: _____

You are being asked to participate in a research study.

Before you agree, your doctor must tell you about the purposes, procedures, and length of the research; any procedures which are experimental; any potential risks, discomforts, and benefits of the research; any potential benefit from other types of procedures or treatments; and how information will be kept confidential.

Where applicable, the investigator must also tell you about any available compensation or medical treatment if injury occurs; the potential for risks; circumstances when the investigator may stop your participation; any added costs to you; what happens if you decide to stop participating; when you will be told about new findings which may affect your willingness to participate; and how many people will be in the study.

If you agree to participate, you must be given a signed copy of this document and a written summary of the research which is written in English.

You may contact _____ at _____ any time you have questions about the research.

You may contact _____ at _____ if you have questions about your rights as a research subject or what to do if you are injured.

Your participation in this research is voluntary, and you will not be penalized or lose benefits if you refuse to participate or decide to stop.

Signing this document means that the research study and the above information has been described to you orally, and that you voluntarily agree to participate.

_____ _____
Signature of Participant Date

_____ _____
Signature of Witness Date