

**Sample Consent Form  
Ethics Review Committee  
Uva Wellassa University**



<Title of the Research Project>

**To be completed by the participant (Please tick the appropriate box)**

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| 1. Have you read the information sheet? (Please keep a copy for yourself)  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you had an opportunity to discuss this study and ask any questions?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you had satisfactory answers to all your questions?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you received enough information about the study?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you understand that you are free to withdraw from the study at any time, without having to give a reason and without affecting your future medical care?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Sections of your medical notes, including those held by the investigators relating to your participation in this study may be examined by other research assistants. All personal details will be treated as strictly Confidential. Do you give your permission for these individuals to have access to your records? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you had sufficient time to come to your decision?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you agree to take part in this study?  | <input type="checkbox"/> | <input type="checkbox"/> |

Who explained you about the study:.....

Signature of the participant:.....

Date:.....

Full name:.....

**To be completed by the Principle Investigator/person obtaining consent**

I have explained the study to the above participant and he/she has indicated her willingness to take part in this study.

Signature of PI:.....

Date:.....

Full name:.....