

## Research Project Information Sheet

### Location of Research (Name of Center)

Dear legal representative :

The Naval Medical Center in cooperation with the (State Department) and the (Name of Collaborator), is conducting a research project titled " " to study:

Your Cooperation is greatly appreciated.

#### **Statement that this project is research:**

**Study Procedures** - If you agree to let your dependent participate, the following procedures will be performed: xxxxxx  
No personal identifiers will be recorded to protect your privacy.

**Risks** - State any risks however minimal they are whether physical or emotional.

**Benefits** - State specific benefit to subject or that the study may not benefit them directly.

**Your dependents participation in this study is entirely voluntary** and the alternative, if you elect not to participate, there will be no penalty and you will receive standard of care medical treatment.

**Confidentiality** - In all publications and presentations resulting from this research study, information about your dependent's participation in this project will be kept in the strictest confidence and will not be released in any form identifiable to them personally.

If you or your dependent have any questions regarding this research study, contact **Dr. *insert full name of local principal investigator*** at *insert phone number, including area code*.

If you have any questions about your dependent's rights as an individual while participating in a research study at the Naval Medical Center, San Diego, you may contact **CAPT George Ulrich, MC, USN, Chairman, Institutional Review Board** at (619) 532-8125, or **Dr. Warren Lockette, MC, USN, Head, Clinical Investigation Department** at (619) 532-8127.

@ \* Enter SHORT TITLE; PI LAST Name, Initial; CIP #S-FY-xxx(get # from CID)

If you believe that your dependent has been injured as a result of their participation in this research study, you may contact **CDR Steven Bannow, JAGC, USN, Naval Medical Center, San Diego, Legal Department, at (619) 532-6475.**

This form is yours to keep for your information. Thank you.

If you have any further Questions or Concerns, Please speak to one of the Physicians.

**SIGNATURE**

You are making a decision whether or not to participate in the research project above. Your signature indicates that you have had this information presented to you, have had the opportunity to ask questions about the research and your participation, and agree to participate in the study. Further, your signature indicates that you have been provided with a copy of this consent document, a Privacy Act and a copy of a document entitled, "California Experimental Subject's Bill of Rights."

**SIGNATURES AND DATE SIGNED:      PRINTED OR TYPED IDENTIFICATION:**

\_\_\_\_\_  
Patient / Subject      (Date)

\_\_\_\_\_  
Name / Status / Sponsor's SSN

\_\_\_\_\_  
Parent/Legal Guardian (Date)

\_\_\_\_\_  
Name / Status / SSN

\_\_\_\_\_  
Relationship to Patient/Subject

\_\_\_\_\_  
Witness                      (Date)

\_\_\_\_\_  
Name / Grade or Rank

\_\_\_\_\_  
Researcher/Investigator(Date)

\_\_\_\_\_  
Name / Grade or Rank