***DIRECTIONS FOR USE OF THIS FORM*:**

* **Instructions and text in red font should be deleted prior to submission.**
* **Final VERSION must be on a WCU Letter Head**

WEST COAST UNIVERSITY

LOS ANGELES CA

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| PRINCIPAL INVESTIGATOR or FACULTY ADVISOR: | PI Name and Title |
| College or Dept. |
| PI Phone number |
| PI Email: |
| 24-hr Telephone Number/Pager | Required for medical studies and clinical investigators |

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| STUDENT INVESTIGATOR **<For Student-directed research>** | Student Investigator Name |
| College/School/Dept |
| Student Investigator Phone (optional) |
| Student Investigator Email: |

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| OTHER INVESTIGATOR(S): **<If applicable, only those researchers that will have direct contact with subjects>** | Other Investigator Name and Title |
| College or Dept. |
| Other Investigator Phone number |
| Other Investigator Email |

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| STUDY LOCATION(S): | Study Location(s) |

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| STUDY SPONSOR(S): | Study Sponsor(s) |

WRITE A BRIEF SUMMARY OF ACTIONS INVOLVING A PARTICIPANT (BEGIN WITH A ONE-PARAGRAPH CONCISE LIST OF PARTICIPANT ACTIONS AS A PART OF THIS STUDY). THIS IS A NEWLY REQUIRED ELEMENT BASED ON THE OHRP COMMON RULE. **THIS SUMMARY GOES HERE** – AT THE START OF THE INFORMED CONSENT.

INCLUDE THE FOLLOWING STATEMENT BELOW:

You are being invited to participate in a research study. Participation in this study is completely voluntary. Read the following information and ask questions about anything that you do not understand.

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| PURPOSE: |  |
| Brief description of study, in lay terms, important to your participant | |

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| NUMBER OF PARTICIPANTS: |  |
| Required: anticipated number of participants | |

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| STUDY DURATION: |  |
| Required: anticipated duration of the study, from the participant’s perspective | |

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| QUALIFICATION(S) TO PARTICIPATE: |  |
| Inclusion/Exclusion criteria (See “Instructions” for required content) | |

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| PROCEDURES: |  |
| Description of procedures, related to the participant – in lay terminology, understandable by the participant | |

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| RISKS: |  |
| Risks to the participant from the research (See “Instructions” for required content) | |

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| BENEFITS: |  |
| Benefits to the participant from the research (See “Instructions” for required content) | |

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| ALTERNATIVE(S) TO PARTICIPATION: |  |
| Alternative(s) to participation in this study (See “Instructions” for required content) | |

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| COMPENSATION or REIMBURSEMENT: |  |
| Compensation or Reimbursement (if applicable) (See “Instructions” for required content) | |

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| COSTS TO PARTICIPATE IN STUDY: |  |
| Costs to subject for participation in the study (See “Instructions” for required content) | |

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| IN THE CASE OF INJURY:IF STUDY POSES NO CHANCE OR RISK – YOU MAY DELETE THIS SECTION. |  |
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*It is important that you* ***promptly tell the researchers*** *if you believe that you have been injured because of taking part in this study. You can tell the researcher in person or call him/her at the number listed at the top of this form.*

*- In the event of any physical injury as a result of being in this study, West Coast University will facilitate to the best of our ability necessary medical services. West Coast University cannot directly provide medical services and does not provide compensation for injury beyond that stated above. Services rendered for the acute care of a study-related injury may be covered by the study sponsor (for industry sponsored studies only), or billed to you or your insurer by your healthcare provider. The University does not normally provide any other form of compensation for injury. Information regarding research-related injury may be directed to the Institutional Review Board at PHONE (323)-454-5049 or by email at IRB@westcoastuniversity.edu*

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| WITHDRAWAL FROM STUDY: |  |
| Explain how a participant may withdraw from the study; and that the investigator may withdraw the participant | |

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| PRIVACY & CONFIDENTIALITY: |  |
| Privacy and confidentiality protections (See “Instructions” for required content) | |

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| ADDITIONAL INFORMATION: | **<If no additional information is necessary, delete this section>** |
| Additional Information (see “Instructions” for content that may be used here) | |

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| CONTACT INFORMATION: |  |
| Names and contact information of all co-investigators having direct contact with subject | |

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| FOR QUESTIONS RELATED TO STUDY or TO REPORT A CONCERN: |  |
| If you have any questions regarding the research or your participation in the study or about the consent form, please contact the Principal Investigator or a designated member of the research team listed above.  If you would like to report a concern about the study or the informed consent process, please contact West Coast University’s Institutional Review Board, by phone (xxx)-xxx-xxxx or, by email at fFarris@westcoastuniversity.edu.   |  |  |  |  |  | | --- | --- | --- | --- | --- | | AUDIO RECORDING: | | **<If not applicable, delete this entire section>** | | | | I have received an adequate description of the purpose and procedures for audio-recording sessions during the course of the proposed research. I give my consent to allow myself to be audio-recorded during participation in this study, and for those records to be reviewed by persons involved in the study, as well as for other professional purposes as described to me. | | | | | |  | **\_\_\_\_­\_Yes**, I agree to allow the research team to **audio record** my interview(s). | | | | |  | **\_\_\_\_­\_No**, I do not wish to have my interview **audio recorded.** | | | | |  |  | | | | |  | Signature of Participant  **<If applicable, include “(or Parent/Legal Guardian)”>** | |  | Date | | |

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| VIDEO RECORDING: | | **<If not applicable, delete this entire section>** | | |
| I have received an adequate description of the purpose and procedures for video-recording sessions during the course of the proposed research. I give my consent to allow myself to be video-recorded during participation in this study, and for those records to be reviewed by persons involved in the study, as well as for other professional purposes as described to me. | | | | |
|  | **\_\_\_\_­\_Yes**, I agree to allow the research team to **video record** *(study procedures, my interview, etc.)* | | | |
|  | **\_\_\_\_­\_No**, I do not wish to have my interview or procedure sessions(s) **video recorded.** | | | |
|  |  | | | |
|  | Signature of Participant  **<If applicable, include “(or Parent/Legal Guardian)”>** | |  | Date |

You should not sign this consent form until all of your questions about this study have been answered. You will be given a copy of this signed and dated consent form to keep. Participation in this study is completely voluntary. You may refuse to answer any questions or discontinue your involvement at any time without penalty or loss of benefits to which you might otherwise be entitled. Your decision will not affect your future relationship with West Coast University, student status or employment.

**I acknowledge that I have received a signed copy of this form and the Research Participant’s Bill of Rights.**

**By signing this document I am indicating that I have read the above information and consent to participate in the research.**

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| Printed Name of Participant |

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| Signature of Participant |  | Date |

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| Signature of Witness (only required if this is a clinical treatment protocol) |  | Date |

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| Signature of Investigator |  | Date |