Informed Consent Form

Study Title:

Study Number:

Subject's Initials: _____ Subject's Name: _____

Date of Birth/Age: _____

Address of the Subject: ___

Qualification: _____

Occupation: Student or Self-Employed or Service or Housewife or Others (Please click as appropriate) .

Annual Income of the subject:

Name and address of the nominees and his relation to the subject (for the purpose of compensation in case of trial related death)

i) I confirm that I have read and understood the information sheet dated _____ for the above study and have had the opportunity to ask questions.

(ii) I understand that my participation in the study is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected.

(iii) I understand that the Sponsor of the clinical trial, others working on the Sponsor's behalf, the Ethics Committee and the regulatory authorities will not need my permission to look at my health records both in respect of the current study and any further research that may be conducted in relation to it, even if I withdraw from the trial.

iv) I agree to this access. However, I understand that my identity will not be revealed in any information released to third parties or published.

(v) I agree not to restrict the use of any data or results that arise from this study provided such a use is only for scientific purposes.

(vi) I agree to take part in the above study.

Signature (or Thumb impression) of the Subject/Legally Acceptable Representative/Legal guardian :

Signatory's Name: _____

Signature of the Investigator: _____ Date: ____ / ____ /

Study Investigator's Name: ___ _____

Signature of the Witness _____ Date: ____ / ____ /

Name of the Witness:_____

Copy of the Patient Information Sheet and duly filled Informed Consent Form shall be handed over to the subject his or her attendant.