Appendix F: Active Informed Consent for Venipuncture and Other Simple Invasive Procedures

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**Required Heading:**

William Paterson University
Project Title:__________________________________________________________
Principal Investigator:__________________________________________________
Investigator’s Contact Phone Number:____________________________________
Other Investigators:_____________________________________________________
Department:___________________________________________________________
Date Protocol Approved:_________________________________________________

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**Additional consent for [insert name for procedure]**

This research is studying [insert descriptive statement].

I understand that approximately [insert amount as formula and words as appropriate] of my blood will be needed. [Insert description of procedure, such as: The procedure involves placing a needle in a vein in my arm to take blood and will require no more than [insert number] minutes. Occasionally there are minor complications, and I may experience bruising, swelling and/or black and blue marks at the site.

I understand that although the results of this test may not benefit me directly, they can be made available to your physician upon request. I understand that data collected during this study will be confidential, except as may be required by law, and any publication resulting from the research will not personally identify any participants. All risks have been explained to me and I accept them. I understand that my decision to take part in this study is voluntary and that medical care will not be affected if I refuse to participate. I may end my participation anytime without prejudice to present or future care. I will be given a copy of this consent form.

Should I wish further information regarding my rights as a research subject, I may contact the IRB Administrator by calling 973-720-2852.

I understand that in the event of physical injury resulting from the research procedure, medical treatment in excess of that covered by third party payers will be provided at no cost to me. I understand that financial compensation is not available for participation in this research.

By signing below, I consent to my participation in the procedure described above.

Name of Subject_________________________ Signature of Subject_________________________
Date: _________________________________

Name of Physician_______________________ Physician’s Phone___________________________

Name of Investigator____________________ Signature of Investigator_______________________
Date: _________________________________

Name of Witness_______________________ Signature of Witness___________________________
Date: _________________________________

NOTE: The signature of witness is only required in certain circumstances that should have been explained and justified in the protocol for this research. In general: do not include a signature block for a witness.