Participant Name­­­­­­­­­­: Date of Birth:

Medical Record #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please **CHECK** next to **“Yes” or “No”** by each line as appropriate **(if “No,” an explanation MUST be provided in the notes section below).**

Yes No I was notified of the participant's eligibility and agreement to take part in the study prior to the conduct of study procedures.

Yes No I, or my designee, on *(date)*\_\_\_\_\_\_\_\_\_\_ reviewed the eligibility requirements and agreed this patient’s participation was appropriate.

Notes­­­­­­:

Principal or Sub Investigator Signature Date