

Diversity in perioperative research study (PROTECT-DIVERSITY)**PARTICIPANT INFORMED CONSENT FORM**

IRAS: 350756

Name of Principal Investigator: *[insert PI name]*Site Name: *[insert site name]*Study ID: *[insert participant's trial ID]*How was consent received (please tick one box): ☐ face to face ☐ remote (e.g. email or post)

Please read each statement and if you agree, put your initials in the box next to it.

1. I confirm that I have read and understood the Participant Information Sheet version x.x dated DD/MM/YYYY for the PROTECT-DIVERSITY study. I have had time to think about the information, ask questions, and I am satisfied with the answers I have been given.	Initial
2. I understand that my participation 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.	Initial
3. I agree to take part in the PROTECT- DIVERSITY study.	Initial

Print Name of participant

Date

Signature

Print Name and role of person taking
consent (Designated responsible person)

Date

Signature

Name:

Role:

If a participant is unable to read or sign this consent form but has capacity to give consent, please complete the following section.

Witness Statement (if applicable):

The participant was unable to read or sign this consent because of the following reason:

I confirm that I was present as a witness to this consent process. I confirm that the participant named above was read the information in the consent document and freely gave their consent to take part in the research trial.

Name and role of witness

Date

Signature
