Clinical Trial Informed Consent and Compensation Agreement

Please read this document carefully. This document provides important information about participating in a clinical trial. After reading, if you agree to participate and accept the terms of compensation, please complete the fields and sign at the bottom of the document to print.

1. Clinical Trial Information

Protocol / Study Title:

Principal Investigator:

Institution / Facility:

2. Participant Information

Full Name of Participant:

Date of Birth (MM/DD/YYYY):

Contact Phone Number:

Email Address:

3. Purpose and Procedures

You are being asked to participate in a clinical trial research study. The purpose of this study is to evaluate the safety and efficacy of the investigational treatment or procedure. Your participation is entirely voluntary. You may withdraw from the study at any time without penalty or loss of benefits to which you are otherwise entitled.

If you agree to participate, you will be asked to undergo various tests, procedures, and follow-up visits as outlined in the study protocol provided by the clinical team.

4. Risks and Benefits

There may be risks, side effects, and discomforts associated with the study drug, device, or procedures. These risks have been explained to you by the study coordinator. While there may be no direct medical benefit to you from participating, the information gained from this trial may help others in the future.

5. Compensation for Participation

In consideration of your time, travel, and adherence to the protocol requirements, you will receive compensation. Please review the agreed-upon payment terms below:

Agreed Compensation Amount per Visit (USD):

Total Expected Number of Visits:

Maximum Total Compensation Amount (USD):

Payments will be issued according to the schedule specified in the study details, typically following the completion of each required visit. If you withdraw early, you will be paid proportionally for the visits you have completed.

6. Compensation for Study-Related Injury

In the event that you suffer a direct physical injury as a result of the study drug or procedure performed in accordance with the study protocol, the institution and/or sponsor will provide necessary medical treatment for the injury at no cost to you. Compensation for lost wages, disability, or pain and suffering is not routinely offered, except as required by law.

7. Confidentiality

Your personal medical and identity records will be kept strictly confidential in accordance with applicable privacy laws (e.g., HIPAA). Representatives of the sponsor, regulatory authorities (such as the FDA), and the Institutional Review Board (IRB) may inspect your records to verify study procedures and data accuracy, but your identity will remain protected.

8. Acknowledgment and Signatures

By filling out and signing below, you acknowledge that:

- You have read and understood the information provided in this consent and compensation agreement.
- You have had the opportunity to ask questions, and all questions have been answered to your satisfaction.
- You voluntarily agree to participate in this clinical trial.
- You agree to the compensation terms outlined in Section 5.

Participant Signature

Printed Name of Participant:

Signature of Participant (Sign after printing):

[Sign Here on Printed Copy]

Date (MM/DD/YYYY):

Investigator Signature

I have explained the nature, purpose, procedures, risks, benefits, and compensation of this clinical trial to the participant, and have answered any questions raised.

Printed Name of Person Obtaining Consent:

Signature of Person Obtaining Consent (Sign after printing):

[Sign Here on Printed Copy]

Date (MM/DD/YYYY):