History :

Version No:

INFORMED VOLUNTEER CONSENT FORM

This form is an example

NAME OF THE RESEARCH (EXPRESS NAME OF THE STUDY):

This study is a scientific research. Before deciding whether you want to participate in the study, it is important to understand why the research is being done, how your information will be used, what the study involves, and its possible benefits and risks. Please take the time to read the following information carefully.

WHAT IS THE PURPOSE OF THE STUDY?

WHAT ARE THE TREATMENTS/PROCEDURES TO BE APPLIED IN THE STUDY? (WHAT IS THE METHOD OF THE STUDY?

WHAT IS THE SCOPE OF THE STUDY?

HOW LONG IS THE WORKING TIME?

WHAT IS THE ESTIMATED NUMBER OF VOLUNTEERS EXPECTED TO PARTICIPATE IN THE STUDY?

Which method will be applied to you will be randomly determined.

WHAT SHOULD I DO WHILE WORKING? If you voluntarily agree to participate in the study, you must allow the evaluation and read and sign this form.

DO I HAVE TO PARTICIPATE IN THIS STUDY?:

It is entirely up to your free will to participate in the study or not. If you decide to participate in the study, you will be given this “Informed Consent Form” to sign. If you decide to participate, you are free to leave the study at any time. This will not affect the standard of treatment you receive, and you will continue any necessary treatment.

Please note that the principal investigator conducting the study (Study Physician) may decide that your continued participation in the study is not in your best interest and may remove you from the study for your benefit.
You are dismissed from the study; This will be the case if your doctor decides to stop you from taking part in the study because you no longer meet the eligibility criteria for participation in the study or your health is compromised in any way, or if the researchers are no longer able to contact you.

POSSIBLE SIDE EFFECTS AND RISKS EXPECTED BY PARTICIPATION IN THE STUDY
WHAT ARE THEY?

WHAT ARE THE POTENTIAL BENEFITS OF PARTICIPATING IN THE STUDY?

WHAT IS THE COST OF PARTICIPATING IN THE STUDY?

In accordance with the principle of not conducting scientific studies with financial concerns, you do not need to pay anything to participate in this study. You will not be paid anything for your participation.

HOW WILL MY CHILD'S PERSONAL INFORMATION BE USED?

By signing this form, you will consent to your research physician and his or her staff collecting and using your personal information (Study Data) for the study.
This consent you give regarding the use of all your personal data, such as your date of birth and gender, is valid indefinitely and does not have any expiry date. If you do not want your data to be used, you can revoke your consent at any time by informing your doctor.

Researchers conducting the study, the ethics committee and relevant health authorities will be able to directly access your medical records when necessary, but this information will be kept confidential and will not be shared with the public. The results of the study may be published in medical publications, but your identity will remain confidential in these publications.
You have the right to ask your doctor for information about your collected study data at any time. You also have the right to request correction of any errors in this data. If you have a request regarding these issues, consult your doctor.
If you revoke your consent, your doctor will no longer be able to use your study data or share it with anyone, even if your identity is confidential.

WILL I BE INFORMED AT THE END OF THE RESEARCH?
When you request, your evaluation results will be shared with you verbally and you will be given feedback about the quantitative data obtained from the scales.

RESPONSIBLE PEOPLE YOU CAN CONTACT WITH ANY QUESTIONS:

HOW MAY NEW INFORMATION AFFECT MY ROLE IN THE WORK?
Any new information that emerges during the study will be communicated to you immediately.

VOLUNTARY PARTICIPATION DECLARATION

I make my decision to participate in this research completely voluntary. I understand that I can refuse to participate in this study or that I have the right to withdraw at any time after participating without any liability. I am aware that this situation will not affect the care and treatments I will receive at the health institution. If I leave the study at any time, I will evaluate with my doctor the reasons for leaving, the consequences of my withdrawal, and the treatments I will receive in the following period.

APPROVAL TO PARTICIPATE IN THE STUDY

I discussed all the above explanations in detail with my doctor and he answered all my questions about my treatment. I have read and understand this informed consent document.

I agree to participate in this research without any pressure and I sign this consent document of my own free will. I understand that this consent does not override any legislative provision that protects my legal rights. My doctor has given me a copy of this document for me to keep and a document containing the points I will pay attention to during the study.

Patient's Name and Surname: *History:* *Signature:*

If any

Parent/ Guardian's Name and Surname: *History:* *Signature:*

Making the statements

Name and Surname of the Researcher: *History:* *Signature:*