# Indiana University Informed Consent Statement [and Authorization] for Research

**[Insert Protocol Title]**

**[Insert IRB Protocol Number]**

**[Insert Sponsor Name and Sponsor Protocol Number, if applicable]**

You are being asked to participate in a research study. This consent [and Authorization] form will give you information about this study to help you decide whether you want to participate. It is your choice whether or not you want to be in this research study. Please read this form, and ask any questions you have, before agreeing to be in this study.

## Important Things to Know:

[Write a concise and focused summary of the **key information** most likely to assist a subject in understanding **why they may or may not want to participate in the study**. If consent is concise as written (no more than a few pages), this section is not required and you can instead start with the Why Is This Study Being Done section.

Be creative with format and language. Consider including bulleted lists, pictures, icons, or flowcharts to describe your study.

Avoid large paragraphs of text. Additional guidance about the concise presentation is available at <https://research.iu.edu/compliance/human-subjects/guidance/informed-consent.html>.]

**Please review the rest of this document for more details about this study and the things you should know before deciding whether to participate.**

## Why is This Study Being Done?

[Insert explanation for why the research is being done. Use language understandable to the subject (i.e., eighth grade level).]

[If the study involves the use of an investigational drug or device, explain that “investigational” means it is not approved by the Food and Drug Administration (FDA).]

We are asking you if you want to be in this study because [Insert explanation regarding how and/or why the subject was identified]*.*

The study is being conducted by [Insert investigator(s) name(s) and University/Departmental affiliation]. It is funded by [Insert Sponsor name, if any, and include if the Sponsor is also the manufacturer of the drug/device being studied, if applicable].

## How Many People Will Be in the Study?

[**This section is only required for greater than minimal risk research. Otherwise, this section can be deleted.]**

You will be one of [Insert number] participants taking part in this study. [For multi-center studies, include both the local and multi-site number of subjects.]

## What Will Happen During the Study?

[Insert explanation of all procedures/tests that are included in the study using language understandable to the subject (i.e., eighth grade level). This should include, when applicable, randomization, assignment to study groups, study visits, administration of study medications, x-rays or imaging, blood draws, collection of information from medical records, surveys and questionnaires, audio or video recordings, and all other study procedures.

For each procedure, explain:

* Where the procedures are performed
* How frequently they are performed
* The expected amount of time each procedure and/or visit will last
* If applicable, whether the procedure is part of usual care for patients
* For measurements, such as blood draws, translate the amount to common measurement terms (e.g., teaspoons or cups; note that 5 ml = 1 teaspoon, 15 ml = 1 tablespoon)

Include the total duration of subject participation, e.g., You will be in this study for about two years.]

[If **clinically relevant** results will be generated by the research but will NOT be given to subjects]: We will not share the results of these tests or procedures with you because they are being done only for research purposes.

[If you **will return research results** to participants, carefully customize the following language to align with your plan for returning results. See the IU HRPP Guidance on [Returning Research Results](https://research.iu.edu/compliance/human-subjects/guidance/returning-research-results.html) for details about creating a plan and important considerations. The three bullets below correspond to the four categories of results discussed in the guidance. You should only include bullets for the categories that are appropriate for your study. You may not need all three, or you may need to draft new language to fit your plan. Where possible, consider incorporating this information within the description of each procedure above rather than as its own section.]

Because we are doing [list procedure(s) that may generate clinically relevant results, e.g., blood tests, an MRI, etc.], we may learn things about you that could be important to your health or interesting to you. We will share the following information with you:

* [If your study will generate information critical to the management of a participant’s health in the immediate/near future]:Any information that might be immediately critical to your health, such as [provide example(s)], will be shared with you or your health care provider.
* [If your study will generate information that has known implication for health or risk AND is clinically actionable]:We will also share [Describe information to be shared, e.g., genes that may suggest you have an increased risk of [disease]; lab tests, x-rays, or other images that may suggest you have a disease that could be treated]. This information likely isn’t something that you need to take action on immediately but may be helpful for your health in the future. [You are encouraged to allow subjects to opt-in/out of receiving this information. If your plan for sharing results includes opt-in/out, include options and initial lines for subjects to indicate whether they want to receive information. See [Guidance](https://research.iu.edu/compliance/human-subjects/guidance/returning-research-results.html) for details.]
* [If your study will generate information that is not clinically actionable OR not known to have any implication for health or risk]:During this study, we may [also] learn things about you that you may find interesting but probably will not help you. Health care providers may not know what the information means or what to do about it. Examples include [describe]. Some people find this kind of information confusing or stressful. You can choose whether to receive this information. [Include options and initial lines for subjects to indicate whether they want to receive information. See [Guidance](https://research.iu.edu/compliance/human-subjects/guidance/returning-research-results.html) for details.]

You might want or need to meet with a doctor or other professional to help you decide what to do with this information. We do not have money available to pay for any follow-up consultations, testing, or treatments.

[If results of genetic testing will be shared with subjects, describe any applicable genetic risks including paternity misattribution and the effects of the knowledge that one is the carrier of a disease gene that might affect their life course. If applicable, also include the risks of stigmatization of a subject or group, generational conflict within a family, or harm to relatives. List the precautions that will be taken to minimize the potential harm of receiving bad news.]

## What Are the Risks of Taking Part in the Study?

[Insert explanation of the reasonably foreseeable risks, side effects, and/or discomforts of each of the procedures using language understandable to the subject (i.e., eighth grade level). Where possible, use bulleted lists or charts rather than paragraphs of text. Include an explanation of measures that will be employed to minimize the risks.

If the list of risks is longer than ½ to 1 page, add sub-headings grouping risks for each major procedure (e.g., Risks of Study Drug, Risks of MRI, Risks of Blood Draw, Other Risks, etc.)

Examples of risk statements with protection procedures. Include only if applicable.

* Common side effects associated with taking the study drug are confusion, sleepiness, depression, anxiety, and headaches. Side effects that occur more rarely include hair loss, rash, and pain or tingling in your hands or feet. We will ask you about any side effects at each study visit. [Be sure to include risks and side effects of all medications given to subjects for the purpose of the study, as well as the likelihood of the risks and/or side effects (e.g., rare or common, or provide a percentage)]
* The risks of drawing blood include pain, bruising, and, rarely, infection. Blood will be drawn by experienced staff members. [If applicable: We will also try to collect blood for the study when you are already getting a blood draw for your regular medical care.]
* Some of the survey questions may make you uncomfortable or upset. You can skip any questions that you do not want to answer.
* Someone outside the study team could get access to your research or medical information from this study.

[If appropriate (e.g., for drug studies), insert the following:]There may be other side effects that we cannot predict. If you become pregnant while you are participating in this study, this may include risks to the fetus.

## Who Will Pay for my Treatment if I am Injured?

**[This section is only required for research that has physical risks listed above. Otherwise, this section should be deleted.]**

[If a source of funds for payment of treatment costs is available:

Insert a description of the source and conditions for payment of those costs. IU expects industry sponsors to compensate subjects for research-related injury. Language used should be detailed and consistent with the contract with the sponsor but should be phrased in a way that is understandable to subjects. Note that if the sponsor is providing compensation for injury, and the subject has government payor insurance, the government payor cannot be billed. The sponsor must directly cover these costs.] Signing this form won’t take away any of your legal rights if you are injured.

[If a source of funds for payment of treatment costs is NOT available, insert the following:]

If you have an injury or illness as a result of participating in the study, [insert one of the following: necessary medical treatment will be provided to you and billed as part of your medical expenses OR you will be responsible for seeking medical care and for the expenses associated with any care received]. Any costs not covered by your medical insurance will be your responsibility. We don’t have money set aside to pay for these types of injuries. However, signing this form won’t take away any of your legal rights if you are injured.

## What Are the Benefits of Taking Part in the Study?

[Insert a statement of potential benefits. Examples include:

We don’t think you will have any personal benefits from taking part in this study, but we hope to learn things that will help other people in the future.

Participating in this study may lessen the symptoms of your disease. However, we don’t know for sure. We are doing this research study to find out if this treatment helps or not.]

## Will I be Paid for Participating?

[Insert one of the following:]

You will not be paid for participating in this study.

**OR**

[Insert a description of the details and any conditions of payment, including if partial payment is applicable.]

[For research involving payment of $600 or more in one calendar year, insert the following:] In order to pay you, we will need your Social Security number (SSN) or tax identification number (TIN). If you are paid $600 or more in one year, you will receive a 1099 tax form in January, and you will need to report this payment as income when you file your tax return. If you have questions about how this impacts your taxes, please talk with a tax expert before deciding whether to participate.

## Will it Cost Me Anything to Participate?

**[This section is only required for research that may result in costs to subjects. Otherwise, this section should be deleted.]**

Taking part in this study may lead to extra costs to you or your insurance company. You or your insurance company will be charged for [insert a detailed list of the procedures, tests, office visits, medications, etc. for which the subject or the subject’s insurance is responsible].

You will not be billed for [insert a list of the procedures, tests, visits, medications, etc. for which the study will pay]. You should check your medical bills to be sure you are billed correctly.

[If appropriate, include the following:] If [name of study drug] is approved by the FDA during the study and becomes commercially available, you or your insurance company may have to begin paying for the drug.

## What Are the Other Treatment Options?

**[This section is only required for treatment/therapeutic research. This section should be deleted if the research is not intended as potential treatment for the subject’s medical condition.]**

There may be other options for treatment of your [insert applicable condition]. [Insert details regarding other possible treatment options such as surgery, drug treatment, management of symptoms, etc.]

## How Will My Information [and Specimens] be Used?

[If the study is subject to HIPAA and this document will serve as the consent and Authorization, include the following. In general, this language should not be edited.] The study team will collect information about you from your medical records. This may include information that can identify you, such as your name, contact information, and medical record number. Information from your medical records will be used to [insert description of the purpose of each use or disclosure of identifiable health information (e.g., make sure you meet the criteria to be in this study, review results of your medical tests for safety purposes, and check on your health in the future to help answer our research question, etc.].

[If the study is subject to HIPAA and this document will serve as the consent and Authorization, include one of the following options. In general, this language should not be edited.]

The information released and used for this research will include all of your medical records. This may include information about mental health, alcohol or substance abuse, HIV/AIDS, sexually transmitted diseases, and/or results of genetic testing.

**OR**

The information released and used for this research will include:

* Hospital discharge summary
* Radiology records
* Medical history/treatment
* Medications
* Consultations
* Radiology films (like X-rays or CT scans)
* Laboratory/diagnostic tests
* EKG reports
* EEG reports
* Psychological testing
* Pathology reports
* Operative reports (about an operation)
* Pathology specimen(s) and/or slide(s)
* Diagnostic imaging reports
* Dental records

If any of the following sensitive types of records will be accessed, they must be specifically noted in the consent:

* Mental health records/psychotherapy notes
* Alcohol/substance abuse
* HIV or AIDS
* Sexually transmitted diseases
* Genetic testing

[If the study is subject to HIPAA and this document will serve as the consent and Authorization, include the following. In general, this language should not be edited.] If you agree to participate, you authorize the following to disclose your medical record information:

* Indiana University Health
* Indiana University Health Physicians [include specialty]
* IUMG – Primary Care Physicians
* Eskenazi Health
* Indiana Network for Patient Care (INPC)
* [Insert name of health care organization(s) or provider(s) not listed above]
* Other: [blank space for participant to complete]

[Include the following language for **ALL** studies, even those not subject to HIPAA.]

The following individuals and organizations may receive or use your identifiable [health] information:

* The researchers and research staff conducting the study
* The Institutional Review Boards (IRB) or its designees that review this study
* Indiana University
	+ [If the study will be conducted at the ICRC:] The Indiana Clinical Research Center (ICRC)
* State and Federal government agencies as permitted by law [if any of the sub-bullets below are included, also add:], including but not limited to:
	+ [For federally-funded research:] Office for Human Research Protections (OHRP)
	+ [For NIH sponsored research:] National Institutes of Health (NIH)
	+ [For research funded or supported by NCI:] National Cancer Institute (NCI)
	+ [For FDA regulated research and research involving positron-emission scanning:] The United States Food and Drug Administration (FDA)

[Include the following as applicable. Delete all lines that do not apply.]

* Research teams at other institutions or research sites: [list]
* Data safety monitoring boards and others authorized to monitor the conduct of the study
* The following research sponsors: [list]
* Contract research organizations: [list]

[If the study is subject to HIPAA and this document will serve as the consent and Authorization, include the following. In general, this language should not be edited.] After your medical record information is released for purposes of this research study, your information may no longer be protected under federal privacy laws, such as HIPAA. However, your identifiable information will still be stored securely and only used as described in this consent.

Information [and specimens] collected for this study may be used for other research studies or shared with other researchers who are conducting their own research studies. This may include sharing with researchers outside Indiana University and sharing with private companies. It may also include making the information available in public and private databases of research data so that other researchers can use the information to answer research questions.

If we share your information [or specimens] in this way, we will remove information that could identify you, such as your name and contact information, before any information [or specimens] are shared. Since identifying information will be removed, we will not ask for your additional consent for this sharing. [If re-identification is possible (i.e. more than a theoretical risk), insert a statement to that effect and describe any risks.]

[If specimens may be used for commercial profit, insert the following:] Additionally, your specimens may be used to develop products which could be sold in the future. If this happens and any profits are made from selling the products, those profits would not be shared with you.

[If the study is an FDA-regulated or NIH-funded clinical trial, insert the following:] A description of this clinical trial will be available on [ClinicalTrials.gov](http://clinicaltrials.gov/), as required by U.S. law. This website will not include information that can identify you. At most, the website will include a summary of the results. You can search this website at any time.

[If the research involves the storage and maintenance of identifiable private information or biospecimens for future use:] [Insert a description of the proposed use, collection and storage procedures, procedures for oversight of security and maintenance, who will have access, procedures to protect confidentiality, procedures for withdrawal, etc. For more information, see Guidance on [Biospecimens](https://research.iu.edu/compliance/human-subjects/guidance/areas/biospecimens.html).]

## How Will My Information be Protected?

We will do our best to keep your personal information private, but we cannot promise complete confidentiality. We won’t share any information that we think could be used to identify you in publications about this study. However, your personal information may be shared outside the research study as described above and/or if required by law.

[If audio or video recordings will be made, insert an explanation regarding who will have access to the recordings, if the recordings will be used for other non-research purposes (such as educational), and when the recordings will be destroyed.]

[If the study is NIH funded, you automatically receive a Certificate of Confidentiality, and must include the following two paragraphs. If the study is not NIH funded, but the study has obtained or intends to obtain a Certificate, insert the following, as appropriate:] This research is covered by a Certificate of Confidentiality from the National Institutes of Health. This means that information, documents, or specimens from this study that could identify you cannot be used in any legal action or lawsuit unless you say it is okay.

There are some types of sharing the Certificate does not apply to. The Certificate does not stop reporting required by federal, state, or local laws, such as reporting of child or elder abuse, some communicable diseases, and threats to harm yourself or others. The Certificate also does not stop sharing of information as described in the How Will My Information be Used section above.

## What Will You Do With My Genetic Information?

**[Required only for studies collecting or using biospecimens for genetic studies/sequencing. Otherwise, this section should be deleted.]**

The specimens collected in this study will be used for genetic studies which may include taking your DNA from the specimens. We may [or will not] use the specimens collected as a part of this study for whole genome sequencing, which involves mapping all of your DNA. Every person’s DNA is unique; therefore, it may be possible for someone to find out who you are just from knowing your DNA sequence.

[If applicable, particularly for NIH-funded studies:] We may send your DNA information or de-identified specimens to a government database, such as the National Institutes of Health’s Database for Genotypes and Phenotypes (dbGaP). These databases allow researchers from around the world who have received approval to use the samples or data for future research. These databases will not contain any identifying information about you. However, we cannot guarantee that no one will ever be able to use your genetic information to identify you.

## What Financial Interest Does the Researcher Have?

**[Required only when an investigator has a financial interest deemed related to the research by the Conflict of Interest or IRB office. Otherwise, this section should be deleted.]**

[Insert description of individual and nature of interest, e.g., Dr. XXX provides consulting services for the sponsor of this study.] We are giving you this information so you can decide if this affects your willingness to participate in this study. If you would like more information, please ask the researchers or study staff.

## Who Should I Call with Questions or Problems?

For questions about the study [or a research-related injury], contact the researcher, [Insert name of investigator], at [Insert telephone number]. [You may also include an email address.] After business hours, please call [Insert alternate number and person/title the subject should request (e.g., on-call physician)].

In the event of an emergency, you may contact [Insert name of investigator] at [Insert 24-hour emergency number].

[If this is an investigational drug study using IU Health IDS, insert the following:]If you are unable to reach the investigator at the above number(s) in an emergency, you may contact the University Hospital pharmacy at 317-944-0362 and ask them to page the IDS pharmacist on call.

For questions about your rights as a research participant, to discuss problems, complaints, or concerns about a research study, or to obtain information or to offer input, please contact the IU Human Research Protection Program office at 800-696-2949 or at irb@iu.edu.

## What if I Do Not Want to Participate or Change my Mind?

After reviewing this form and having your questions answered, you may decide to participate in the study. Or, you may choose not to participate in the study. This decision is up to you. If you choose not to participate in this study or change your mind after signing this document, it will not affect your relationship with Indiana University [if conducted in medical facility:] or the medical care you receive from [insert appropriate entity: IU Health, Eskenazi Hospital, Riley Hospital for Children, etc.].

If you change your mind and decide to leave the study in the future, the study team will help you withdraw from the study safely. If you decide to withdraw, [explain the procedure for withdrawal from the study]. [If withdrawal from the study prior to completion could pose risk to the subject, insert a description of what those risks might be and how orderly termination will occur.]

[If the study is subject to HIPAA and this document will serve as the consent and Authorization, include the following. In general, this language should not be edited.] If you choose to withdraw your authorization for use and disclosure of your protected health information, you must do so in writing by notifying [name and mailing or email address]. If you withdraw your authorization, you will not be able to continue in this study. However, even if you cancel this authorization, the research team, research sponsors, and/or the research organizations may still use information about you that was collected as part of the research project between the date you signed this document and the date you cancelled this authorization. This is to protect the quality of the research results. Otherwise, this authorization remains valid until the research ends and required monitoring of the study has been completed [OR insert date or description of a specific event or circumstance].

[If appropriate, insert the following:] The researchers may stop your participation in the study even if you do not want to stop if [Insert a description of when and why study participation may be terminated and how orderly termination will occur. If applicable, include: the sponsor decides to end the study early].

[If appropriate, insert the following:] You will be told about new information that may affect your health, welfare, or willingness to stay in the study.

## Agreement to be Contacted by Text and/or Email

[Optional section: remove if you do not want to use text or email communications] We would like to communicate with you about this study by text message and/or email. We might use text or email to [insert brief description of purposes: for example, send you reminders about upcoming visits or appointments, check on how you are doing, or tell you about the progress of the research.]

Text messaging and email are not secure methods of communication. The information sent over text or email, which may include sensitive or personal information, such as protected health information, could be accessed or read by someone other than you. If you would like us to communicate with you via text or email, please initial the lines below and provide the phone number(s) and/or email address(es) you would like us to use.

\_\_\_\_\_\_ I authorize the researchers to send me emails related to this research study

Email address for this communication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_ I authorize the researchers to send me text messages related to this research study

Phone number for this communication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

You can still participate in this study even if you do not want us to contact you by text or email.

## Participant’s Consent [and Authorization]

I agree to participate in this research study.

**Participant’s Printed Name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Participant’s Signature:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date:**\_\_\_\_\_\_\_\_\_\_\_

**Participant’s Address:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*(include street address, city, state, and zip code)*

**[Address required only when document is being used as a HIPAA Authorization]**

**Printed Name of Person Obtaining Consent:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Person Obtaining Consent:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date:**\_\_\_\_\_\_\_\_\_\_

[**FOR RESEARCH INVOLVING CHILDREN, USE THE FOLLOWING SIGNATURE BLOCKS, AS APPLICABLE]**

**Printed Name of Child:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Child’s Address:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
*(include street address, city, state, and zip code)*

**[Address required only when document is being used as a HIPAA Authorization]**

**Printed Name of Parent:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of Parent**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date:**\_\_\_\_\_\_\_\_\_\_

**[If a 2nd parent signature is NOT required, REMOVE the 2nd parent signature block below]**

**Printed Name of 2nd Parent:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature of 2nd Parent**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date:**\_\_\_\_\_\_\_\_\_\_

**[If the child participant will NOT sign this document, REMOVE the child signature block below]**

**Signature of Child**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date:**\_\_\_\_\_\_\_\_\_\_

[**FOR RESEARCH INVOLVING INDIVIDUALS LACKING CONSENT CAPACITY, USE THE FOLLOWING SIGNATURE BLOCK]**

**Research Participant’s Printed Name:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Research Participant’s Address:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
*(include street address, city, state, and zip code)*

**[Address required only when document is being used as a HIPAA Authorization]**

**Printed Name of LAR:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
*(Legally authorized representative)*

**Signature of LAR**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date:**\_\_\_\_\_\_\_\_\_\_