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CanaCare

PARTICIPANT CONSENT FORM

I, ... [PRINT NAME], agree to take part in this research study.

In giving my consent I state that:

- ✓ I understand the purpose of the study, what I will be asked to do, and any risks/benefits involved.
- ✓ I have read the Participant Information Statement and have been able to discuss my involvement in the study with the researchers if I wished to do so.
- ✓ The researchers have answered any questions that I had about the study and I am happy with the answers.
- ✓ I understand that being in this study is completely voluntary and I do not have to take part. My decision whether to be in the study will not affect my relationship with the researchers or anyone else at the University of Sydney, University of New South Wales, and Cana Communities, now or in the future.
- ✓ I understand that I can withdraw from the study at any time.
- ✓ I understand that personal information about me that is collected over the course of this project will be stored securely and will only be used for purposes that I have agreed to. I understand that information about me will only be told to others with my permission, except as required by law.
- ✓ I understand that the results of this study may be published, and that publications will not contain my name or any identifiable information about me.
- ✓ I understand that my GP or other medical practitioners may be contacted for further relevant medical information.
- ✓ I understand that I may see a variety of health professionals.

THE UNIVERSITY OF SYDNEY

CANACARE

I consent to:

- Seeing CanaCare research personnel in-person and via online platforms YES ☐ NO ☐
- **Being contacted about future studies** YES ☐ NO ☐
- **Receiving feedback about my personal results** YES ☐ NO ☐
- **Taking part in video and audio recordings that may be used for educational purposes with other study participants, health care professionals, and students, as well as for measurement of study reliability purposes.** YES ☐ NO ☐
- **Take part in photographs that may be used for educational purposes with other study participants, health care professionals and students, as well as for measurement of study reliability purposes.** YES ☐ NO ☐
- **Would you like to receive feedback about the overall results of this study?** YES ☐ NO ☐

  If **YES**, please indicate your preferred form of feedback and address:

  ☐ Postal: _____

  ☐ Email: _____

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PARTICIPANT CONSENT FORM

.....

Participant's PRINT name

.....

Participant's Signature

.....

Witness's PRINT Name

.....

Witness's Signature

.....

Date