### Instructions are in blue; bolded items must be included.

### *Before submission to the IRB*: Remove instructions and any bold emphasis.

* Consider using large font if you anticipate recruiting participants with visual impairments, e.g., older populations, or for eye studies

**DESCRIPTION:** You are invited to participate in **a research study** on (*describe project in non-technical language; include types of questions that will be asked, if applicable; explain* ***purpose*** *of the research).* You will be asked to *(describe* ***procedures****; mention video/audio recording, if applicable, and what will become of recordings after use, e.g., shown at scientific meetings; describe the final disposition of the recordings).*

**TIME INVOLVEMENT:** Your participation will take approximately *(insert* ***duration****).*

**RISKS AND BENEFITS:** The risks associated with this study are *(describe* ***foreseeable risks*** *to participants; if none, state as such).*Study data will be stored securely, in compliance with Stanford University standards, minimizing the risk of confidentiality breach. The benefits which may reasonably be expected to result from this study are *(describe any* ***benefits****; if none, state as such).* **We cannot and do not guarantee or promise that you will receive any benefits from this study.** *(Include the following sentence if applicable)* Your decision whether or not to participate in this study will not affect your *(choose as appropriate): employment; medical care; grades in school.*

**PAYMENTS:** You will receive *(describe reimbursement; where there is none, state as such)* as payment for your participation.

If participants will be paid $200 or more, add the following statement:

\*Payments may only be made to U.S. citizens, resident non-citizens, and those who are in a status that allows them to receive a taxable payment from a U.S. payer. You may need to provide your social security number to receive payment.

**PARTICIPANT’S RIGHTS:** If you have read this form and have decided to participate in this project, please understand your **participation is voluntary** and you have the **right to withdraw your consent or discontinue participation at any time without penalty or loss of benefits to which you are otherwise entitled**. **The alternative is not to participate.** You have the right to refuse to answer particular questions. The results of this research study may be presented at scientific or professional meetings or published in scientific journals. Your individual privacy will be maintained in all published and written data resulting from the study.

If identities will be disclosed, provide details and include the following statement: With your permission, your identity will be made known in written materials resulting from the study.

**\*If this research study collects identifiable private information, you must include one of the following 2 statements.** These statements define the ways research data may (or may not) be used for future research. Federal regulations require that one of the following statements be included in the consent forms for any study that collects identifiable private information.

**Statement 1**: This statement allows for the sharing and future research use of non-identifiable data collected for this research project.

In accordance with scientific norms, the data from this study may be used or shared with other researchers for future research (after removing personally identifying information) without additional consent from you.

OR

**Statement 2**: This statement prohibits any future research use of data collected under this protocol, even by investigators named on this protocol. Including this statement indicates that the data collected for this research will never be used again.

Your private information collected as part of the research, even if identifiers are removed, will not be used or distributed for future research studies.

**CONTACT INFORMATION:**

***Questions:*** If you have any questions, concerns or complaints about this research, its procedures, risks and benefits, contact the Protocol Director,*(name, email address, and phone number of Protocol Director).*

***Independent Contact:*** If you are not satisfied with how this study is being conducted, or if you have any concerns, complaints, or general questions about the research or your rights as a participant, please contact the Stanford Institutional Review Board (IRB) to speak to someone independent of the research team at 650-723-2480 or toll free at 1-866-680-2906, or email at irbnonmed@stanford.edu. You can also write to the Stanford IRB, Stanford University, 1705 El Camino Real, Palo Alto, CA 94306.

*(If applicable)* ***Appointment Contact:*** If you need to change your appointment, please contact (*name*) at (*phone number*).

Indicate ***Yes*** or ***No***:

*(If applicable)* I give consent to be audio recorded during this study.

 \_\_\_Yes \_\_\_No

*(If applicable)* I give consent to be video recorded during this study:

 \_\_\_Yes \_\_\_No

*(If applicable)* I give consent for recordings resulting from this study to be used for *(describe proposed use of recordings)*:

 \_\_\_Yes \_\_\_No

*(If applicable)* I give consent for my identity to be revealed in written materials resulting from this study:

 \_\_\_Yes \_\_\_No

If you would like to contact participants about future studies, include the following statement:

May we contact you about future studies that may be of interest to you?

\_\_\_\_ Yes \_\_\_\_ No

The paragraph below must be included in all studies involving COVID-19 research.

****The federal government has issued a Declaration that may limit your right to sue if you are injured or harmed while participating in this COVID-19 study. If the Declaration applies, it limits your right to sue researchers, healthcare providers, any study sponsor, manufacturer, distributor or any other official involved with the study. However, the federal government has a program that may provide compensation to you or your family if you experience serious physical injuries or death. To find out more about this “Countermeasures Injury Compensation Program” please go to [https://www.hrsa.gov/cicp/about/index.html or call 1-855-266-2427](https://www.hrsa.gov/cicp/about/index.html%20or%20call%201-855-266-2427).

**The extra copy of this signed and dated consent form is for you to keep.**

**SIGNATURE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE \_\_\_\_\_\_\_\_\_\_\_\_**

**Print name of participant** **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**