

Optional: Insert EMC, VTH or ACCRC logo here
Address: [Company Address]
Phone: [Company Phone]

**Clinical Research Project
Client Consent Form**

**Study Title:** Click here to enter text. 1

**Principal Investigator:** Click here to enter text.

 PI Phone Number and Email Address

One of the missions of the Virginia-Maryland College of Veterinary Medicine is to create, disseminate and apply medical knowledge through discovery, learning, and engagement. You are invited to participate in this mission by enrolling your animal in a clinical research study. Your participation is voluntary, and you may withdraw your animal from the study at any time by notifying the Principal Investigator. There is no penalty if you choose not to participate.

**Study Purpose:**

Brief, lay language overview, include whether treatment is experimental

**Study Design/Procedures:**

Brief, lay language overview of design and procedures. Describe assignment to study groups, duration of study and frequency of visits. Indicate if study participation involves withholding of standard treatment. Describe in lay terms the conditions that would prompt discontinuation of the clinical trial protocol.

**Risks and Benefits:**

Lay description of corresponding IACUC section (if available), including risks of withholding standard treatment if applicable.

**Study Costs and Compensation:**

If applicable. Compensation can be combined with the Benefits section above. List any costs not covered by the study.

**Confidentiality:**

The data collected in the course of this study is confidential. In any publication or presentation of the study data, we will not include information that would make it possible to identify a research participant. Research records will be kept in a secure location; only researchers will have access to the records.

*Indicate if sponsor will have access to study data.*

**Statement of Consent:**

In giving my consent by signing this form, I acknowledge that I have been informed of the purpose and nature of this study and its associated procedures, as well as any possible side effects.

I have read and understood the above information. I have been given the opportunity to ask questions and receive answers, and I consent to participate in the study. I further certify that I am the owner (or duly authorized agent of the owner) of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ .

 (Animal’s name)

Owner or Agent Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_

Owner or Agent Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Attending Clinician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_

Attending Clinician Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please don’t hesitate to contact us if you have any questions or concerns about this study.**

The research and procedures have been reviewed and approved by the Virginia Tech Institutional Animal Care and Use Committee and the Virginia-Maryland College of Veterinary Medicine Clinical Research Review Committee.

If you have any questions or concerns regarding the study and would like to talk to someone other than the researchers, please contact:

Hospital Director,

Veterinary Teaching Hospital

Address: 245 Duck Pond Dr.,

Blacksburg, Virginia 24061-0443

Phone: 540.231.4621

OR

Hospital Director,

Equine Medical Center

17690 Old Waterford Road

Leesburg, Virginia 20176

United States

Phone: 703.771.6800

OR

Hospital Director,

Animal Cancer Care and Research Center

4 Riverside Circle

Roanoke, VA 24016

United States

Phone: 540.526.2300

You will be given a copy of this form to keep for your records.