ALTAMASH INSTITUTE OF DENTAL MEDICINE

CONSENT FORM TEMPLATE

Date: ______________________

Research Title:

____
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Researcher's Name: ____

By signing this page, I acknowledge and confirm the following:

- I have thoroughly reviewed the entirety of this Consent Form, including any information pertaining to potential risks associated with this study, and I have had ample time to carefully consider its contents.
- All my questions have been addressed to my satisfaction.
- I willingly agree to participate in this research study, adhere to the study protocols, and provide any necessary information to the doctor, nurses, or other staff members upon request.
- I retain the right to withdraw from this study at any point without repercussions.
- I have received a copy of this Consent Form for my personal records.
- I comprehend that my name will not be disclosed in any published materials, and efforts have been made to protect the confidentiality of my identity. However, due to unforeseen circumstances, complete confidentiality cannot be entirely guaranteed.

Participant Name: ____________________________________

Participant ID: ______________________________________

Signature of Participant / Legal person/ Guardian: ______________________________

Name of Witness: ____________________________________

Signature of witness: ___________________________________

Consent interviewer:

Name: ________________________________

Signature: ______________________________

Note: Submit the edited form in PDF format to RDRC