BHARATI VIDYAPEETH (DEEMED TO BE UNIVERSITY) DENTAL COLLEGE AND HOSPITAL, DHANKAWADI, PUNE 411043
DEPATMENT OF _____

Informed Consent form

Study Title:

Participant Name:

Date:

Registration No. **Age/Sex:** **Address:**

Investigator's Name:

Please read each of the numbered sections below and indicate your agreement with each section by ticking the box to the right of each section, completing all blanks, and signing on the line below.

SR NO.	CONTENTS	CONSENT
1.	I confirm that I have read the **research** study information sheet or it has been read to me, that I understand it, that I have had the opportunity to ask questions about it, and that my questions have been answered to my satisfaction	
2.	I understand that my participation is voluntary and that I have the right to withdraw at any time, without giving any reason and without affecting my medical care or legal rights.	
3.	I have been informed about the risks and discomforts of the study.	
4.	I have been informed about the benefits, purpose and procedure of the study.	
5.	I understand that my report's data will be used for research purpose only and confidentiality will be maintained at all times.	
6.	I understand my responsibilities during the research study and agree to fulfill them.	
7.	I consent voluntarily to participate as a participant in the above research study.	
8.	I am aware that I will be undergoing radiation exposure/drugs/surgical intervention and I agree to participate voluntarily for the same.	

_____ _____

Name of the Participant Name of Researcher

_____ _____

Date and Signature or thumb Impression of the Participant

Signature of Researcher

_____