**CONSENT TO PARTICIPATE IN A RESEARCH STUDY**

**Title of Study:** Optimizing the Adaptive Treadmill Controller

**Principal Investigator(s):** Jane Doe, PhD

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| **KEY INFORMATION YOU SHOULD KNOW ABOUT THIS STUDY**:   * **Purpose**: * **Procedures**: * **Risks and Benefits**: * **Confidentiality**: * **Expenses and Compensation**:   You do not have to participate in this study. Please read the entire document before deciding whether you are willing to participate. You can ask any questions you may have before deciding If you want to participate. |

You are being invited to participate in a research study. This consent form tells you about the study including its purpose, what you will be asked to do if you decide to take part, and the risks and benefits of being in the study. Please read the information below and ask us any questions you may have before you decide whether you want to participate.

**PURPOSE OF THE STUDY**

The purpose of this study is .

**WHO IS BEING ASKED TO PARTICIPATE?**

You will be one of approximately NN participants in this study.

You are being asked to participate because…

* .

**PROCEDURES: WHAT WILL YOU BE ASKED TO DO?**

If you agree to participate in this study, you will be asked to…

* .

**WHAT ARE POSSIBLE RISKS AND DISCOMFORTS?**

* .

**WHAT ARE POTENTIAL BENEFITS FROM THE STUDY?**

* **Direct benefits to you**: .
* **Scientific benefits**: .

**CONFIDENTIALITY: WHO MAY KNOW THAT YOU PARTICIPATED IN THIS RESEARCH?**

Your participation in this study will be confidential. .

The confidentiality of your records will be protected to the extent permitted by law. Your research records may be viewed by the University of Delaware Institutional Review Board, which is a committee formally designated to approve, monitor, and review biomedical and behavioral research involving humans. Records relating to this research will be kept for at least three years after the research study has been completed.

**USE OF DATA COLLECTED FROM YOU IN FUTURE RESEARCH:**

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**COSTS AND COMPENSATION**

* **Costs to you**: .
* **Compensation**:.

**WHAT IF YOU ARE INJURED DURING PARTICIPATION IN THE STUDY?**

If you are injured during your participation in the study, you will be offered first aid at no cost to you. If you need additional medical treatment, the cost of this treatment will be your responsibility or that of a third-party payer (for example, your health insurance). By signing this document, you are not waiving any rights that you may have if injury was the result of negligence of the university or its investigators.

**DO YOU HAVE TO TAKE PART IN THIS STUDY?**

Taking part in this research study is your decision. You do not have to participate in this research. If you choose to take part, you have the right to stop at any time. If you decide later not to participate, or if you decide to stop taking part in the research, there will be no penalty or loss of benefits to which you are otherwise entitled.

Your decision to stop participation, or not to participate, will not influence current or future relationships with the University of Delaware. As a student, if you decide not to take part in this research, your choice will have no effect on your academic status or your grade in the class.

**INSTITUTIONAL REVIEW BOARD**

This research study has been reviewed and approved by the University of Delaware Institutional Review Board (UD IRB). If you have any questions or concerns about your rights as a research participant, you may contact the UD IRB at [hsrb-research@udel.edu](mailto:hsrb-research@udel.edu) or (302) 831-2137.

**CONTACT INFORMATION**

**If you have any questions about the purpose, procedures, or any other issues related to this research study you may contact the Principal Investigator, Dr. Jane Doe at (302) 123-4567 or Jdoe@udel.edu.**

**CONSENT TO PARTICIPATE IN THE RESEARCH STUDY:**

**I have read and understood the information in this form and I agree to participate in the study. I am 18 years of age or older. I have been given the opportunity to ask any questions I had and those questions have been answered to my satisfaction. I understand that I will be given a copy of this form for my records.**

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Printed Name of Participant Signature of Participant Date

(PRINTED NAME) (SIGNATURE)

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Person Obtaining Consent Person Obtaining Consent Date

(PRINTED NAME) (SIGNATURE)

**OPTIONAL CONSENT FOR ADDITIONAL USES OF IDENTIFIABLE VIDEO RECORDINGS/PHOTOGRAPHS**

I voluntarily give my permission to the researchers in this study to use videos and photographs of me collected as part of this research study for publications, presentations, and/or educational purposes. I understand that no identifying information beyond that contained in the video recording will be provided to educational/scientific audiences; however my facial features may be seen.

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(Printed Name of Participant) (Signature) (Date)