Colitis & Crohn's Foundation (India)
CCF

CCF DISEASE REGISTRY

Enrollment & consent form

Name: _____ Date of birth: _____

Father's/Husband's Name _____ Mother's Name: _____

Address: _____ City: _____ State: _____

Telephone no.: Office/Residence: _____ Mobile: _____ Email: _____

INFORMED CONSENT FORM

I, _____

the undersigned, living at _____

agree to take part in the CCF Registry, the purpose of which is to collect and update data of patients with Inflammatory Bowel Disease.

Dr. _____, who is participating in this registry, has given me a full explanation of its nature and purpose. I was able to ask him/her questions regarding all aspects of the registry.

After due consideration, I agree to cooperate with Dr. _____ and allow him/her to enter me as a participant on this registry.

I have noted that I am free to withdraw from the registry at any time, if I so desire.

My identity will never be disclosed (beyond my treating doctor) and the data collected will remain confidential. I agree that they may be examined by those persons involved in the registry under the investigator's delegated authority. I agree that I will not seek to restrict the use to which the results of the study may be put.

Read and Approved:

Name of participant: _____ Signature: _____ Date: _____

Name of witness: _____ Signature: _____ Date: _____

Name of attending physician: _____ Signature: _____ Date: _____

Investigator's signature: _____ Signature: _____ Date: _____

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