*Instructions: If your study may obtain informed consent from a healthcare decision maker, copy and paste the below information into the end of the consent document for IRB review and approval. For such studies, if the patient consents to enroll in the study, check the ‘not applicable’ checkbox during the informed consent discussion to document that this section is meant to remain incomplete for that participant.*

*This document should not be submitted to the IRB as a standalone document.*

**Surrogate Consent Rider for Research**

**Not applicable** – This participant did not enroll utilizing a healthcare decision maker and the surrogate consent rider.

I, \_\_\_\_\_\_\_\_\_\_ [name of decision-maker/surrogate],

am the \_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_ [state relationship to participant]

of \_\_\_\_\_\_\_\_\_\_ [state participant’s name]. I have read the informed consent document or it has been explained to me. I have had the opportunity to ask any questions and all of my questions have been answered. I have been informed that an investigational treatment may be administered to \_\_\_\_\_\_ [participant’s name]. I believe receiving such treatment would be in the interests of [participant’s name] and is consistent with what he/she would have decided had he/she been able to do so.

Your decision to allow your family member/friend to participate in this research study is voluntary. You may choose not to allow his/her participation and he/she will receive alternative treatments without affecting his/her healthcare/services or other rights. You are also free to withdraw him/her from this study at any time. In the event new information becomes available that may affect the risks or benefits associated with this research study or your willingness to allow continued participation in this research study, you will be notified so that you can make an informed decision whether or not to continue your family member/friend’s participation in this study.

Your family member/friend will periodically be re-evaluated for the capacity to give consent. If he/she is found to be capable, continued participation in this study would only occur with his/her consent.

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Signature of Health Care Decision-Maker/Surrogate Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_

Signature of Witness Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_

Name and Signature of person obtaining consent Date