

NIA Aging Cell Repository

MODEL INFORMED CONSENT FORM

I hereby consent to the collection of ____ ml (____tsp) blood or skin biopsy from myself or my child for submission to the Coriell Cell Repository (The CCR), a research resource supported by the National Institutes of Health. The Repository collects, stores, and distributes cell cultures and DNA samples from people with many kinds of disorders, from unaffected family members, and from other healthy people. The purpose of this collection is to make specimens available for use in research and teaching. Submission of my tissue to the Repository may give scientists valuable research material that can help them to develop new diagnostic tests, new treatments, and new ways to prevent diseases.

The CCR will take measures to protect my privacy by breaking any link between my name and the specimen. My blood or tissue specimen will be given a code number and my name will be removed from records associating it with this code. While the CCR may disclose information such as age, sex, diagnosis, and race to scientists, names cannot later be associated with samples. Through this procedure, I understand that the CCR takes every reasonable step to protect my anonymity. Because the link to my name has been broken, the CCR will be unable to provide me with any information about scientific findings that may be submitted to it or appear in the scientific literature.

There will be no direct benefit or payment to me for participating, but my sample may benefit the community at large or some particular group. Because researchers will not have access to my identity, it will not be possible to provide me or my physician with the eventual results of studies that might be performed using my specimen.

The medical risks of providing these specimens are minimal. The risk of venipuncture is minor: transient pain and slight possibility of infection. The risk for skin biopsy is mild: local pain, slight bleeding, the possibility of a small scar, and slight possibility of infection.

It is possible that data resulting from use of my sample may eventually be used in a research publication. In that event, no individual's identifying information will be included, as this information will not be available to the researchers.

My donation is voluntary, and if I choose not to participate there will be no penalty or loss of benefits to which I am entitled. My anonymous sample will stay in the Repository indefinitely and I will not be able to withdraw it.

(Signature) _____

(Relationship) _____

If I have any questions or complications relating to collection of this specimen, or about my rights as a research subject, I should contact (name) _____ (phone) _____, who collected the specimen.

If I have any questions about the Repository, I should contact the Principal Investigator for the NIA Aging Cell Repository, Coriell Institute for Medical Research, 403 Haddon Avenue, Camden, New Jersey 08103. (Telephone: 800-752-3805).

If I have questions about my right as a research subject I should call _____ to talk to a representative of submitter's IRB.

To contact the CORIELL CELL REPOSITORIES:
Write: 403 Haddon Avenue; Camden, New Jersey 08103; USA
Call: 800-752-3805 in the United States; 856-757-4848 from other countries
Fax: 856-757-9737
e-mail: customerservice@coriell.org

To be completed by person obtaining informed consent:

Date	
Name of Person obtaining informed consent	
Job Title/Position	
Address	
Telephone Number	