**CONFIDENTIAL WHEN COMPLETE** *<TO BE PRINTED ON LOCAL TRUST HEADED PAPER>*

# RATE-AF Trial
# Participant Consent Form

**Participant Trial Number:** ☐☐☐☐ **Please initial each box to confirm consent ↓**

**1.** I confirm that I have read and understood the Participant Information Sheet dated: D D / M M M / Y Y Y Y **version** ☐ . ☐ for the above trial. I have had the opportunity to think about the information, ask questions and have had these answered to my satisfaction. ☐

**2.** I understand that my participation in this trial is voluntary and that I am free to withdraw at any time, without giving a reason and without my medical care or legal rights being affected. I understand that data collected up to my time of withdrawal may be used. ☐

**3.** I understand that sections of my medical notes or information related directly to my participation in this trial may be looked at by responsible individuals from the sponsor, regulatory authorities and research personnel where it is relevant to my taking part in research. I give permission for these individuals to have access to my records. ☐

**4.** I understand that my doctor will provide a copy of this consent form and personal information about my progress, in confidence, to the central organisers at Birmingham Clinical Trials Unit (BCTU) for use in the RATE-AF Trial. ☐

**5.** I understand that my General Practitioner will be informed of my participation in this research ☐

**6.** I understand that the trial researchers may contact me by telephone, text or email and that my relevant contact details may be passed to the BCTU to assist with this. ☐

**7.** I understand that my data, collected as part of this research, will be stored securely for up to 25 years and that during this time it may be looked at again by research personnel in relation to the RATE-AF Trial. ☐

**8.** I agree to participate in the RATE-AF Trial ☐

**In order to participate in the RATE-AF trial you <u>MUST</u> consent to points 1-8 above and initial the corresponding boxes.**

| Name of participant | Date | Signature |
|---|---|---|
| | | Witness Signature *(if applicable)* |
| Name of person receiving consent | Date | Signature |

*Original to be filed in the Investigator's Site File; 1 copy for patient; 1 copy to be kept with patient's hospital record; 1 copy to be sent to BCTU*