CONSENT FORM

Title of Study: A Study of Different Types of Treatment for Verrucae.

Investigator's Name: (Podiatrist's Name, position and name of site)

Please initial the boxes.

1. I confirm that I have read and understand the information sheet version [insert number] dated [insert date], or for children under the age of 16 version [insert number] dated [insert date] for the above study and have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without my medical care or legal rights being affected ☐

3. I understand that sections of any of my medical notes may be looked at by responsible individuals from the podiatry department/GP practice at (name of centre) or other members of the NHS Trust, representatives of the Study's Sponsor (university of York) and regulatory authorities, 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 General Practitioner will be informed that I have taken part in this study. ☐

5. I agree to take part in the above study. ☐

6. I agree to have my verruca photographed. ☐

_____	_____	_____
Patient name (please print)	Patient Signature	Date
_____	_____	_____
Name of *Parent/Guardian (*Please delete as appropriate)	Signature of *Parent/Guardia (*Please delete as appropriate)	Date
_____	_____	_____
Name of researcher taking consent (please print)	Signature of researcher	Date

Patient's date of birth ____/_____/_____
day month year

Once completed: 1 copy for the patient, 1 in the site file and 1 in the medical notes