Barcode

Airwave Health Monitoring Study, Health Screening Consent Form

Principal Investigator: Professor Paul Elliott FMedSci

In order to perform the health screen today, we need your permission to perform the clinical procedures and keep your results, samples and data on a long-term basis. Please complete this form by **initialling each box** and **signing at the bottom.**

1.	I have read the *Information Leaflet* (Version 5, dated 6th August 2013), and have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.	
2.	I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.	
3.	I understand that information held by the NHS and records maintained by the NHS Information Centre may be used to keep in touch with me and follow up my health status.	
4.	I give permission for the Study to access my Airwave usage data and the items in my police personnel records stated in the *Information Leaflet*, for long term storage and use of this and other information about me and to link this to my future health.	
5.	I allow the research team to take the health-related measurements described in the *Information Leaflet*.	
6.	I allow the research team to take a sample of blood and urine for analysis *.	
7.	I give permission for long-term storage and use of my blood and urine samples, and for their use by this Study, and future genetic and other research approved by a Research Ethics Committee *.	
8.	I agree to complete a comprehensive health information questionnaire and a cognitive test on the computer.	
9.	I allow results from my health screen to be sent to my GP *(OPTIONAL)*.	
10.	I agree to take part in the Study.	

* You do not have to consent to these clauses to take part in the Study, but your contribution to the research will be greatly enhanced if you do (please leave blank if not consenting).

Print Name	_____	Clinic Location	_____
Signed	_____	Force Name	_____
Date	_____	Employee Number†	_____
Nurse Name	_____	Nurse Signature	_____

† Collar Number, Shoulder Number, Registration or Pay Number, as appropriate for your force.