Research Title:

Umbilical Cord Care in Term Neonates: The Revolutionized Role of Wondaleaf Adhesive Pouch (WLAP) in the Prevention of Neonatal Sepsis

Protocol ID: AURRB/IND/TWIN/2020/01

Document Date: August 25, 2021

Informed Consent Form

Dear participants,

Greeting!

I am Prof. Dr. Yu Chye Wah, the chief investigator in this research project entitled 'Umbilical Cord Care in Term Neonates: The Revolutionized Role of Wondaleaf Adhesive Pouch (WLAP) in the Prevention of Neonatal Sepsis'. The purpose of this study is to evaluate the efficacy of Wondaleaf Adhesive Pouch (WLAP) in the prevention of umbilical cord infection among term neonates. The research is essential to improve the care of umbilical cord among the newborns. My research team from AIMST University and collaborator Putra Medical Centre would like to seek your cooperation to participate in our research project. Your input in this study will be used solely for research purpose and all info you provided will be kept private and confidential. If you have any questions, please ask any member of our research team. We will assist you to ensure smooth implementation of the study.

Your cooperation in this study is highly appreciated.

Thank you.

Yours sincerely,

Prof. Dr. Yu Chye Wah

Chief Investigator

Datin Dr. Lim Hui Ling

Medical Director, Putra Medical Centre

PARENT CONSENT FORM

By signing below, I confirm the following:

- I have been given oral and written information for the above study and have read and understood the information given.
- I have had sufficient time to consider participation in the study and have had the opportunity to ask questions and all my questions have been answered satisfactorily.
- I understand that my participation is voluntary and I can at any time free to withdraw from the study without giving a reason and this will in no way affect my future treatment if I am not taking part in any other research study at this time. I understand the risks and benefits, and I freely give my informed consent to participate under the conditions stated. I understand that I must follow the study doctor's (investigator's) instructions related to my participation in the study.
- I understand that study staff, qualified monitors and auditors, the sponsor or its affiliates, and governmental or regulatory authorities, have direct access to my medical record in order to make sure that the study is conducted correctly and the data are recorded correctly. All personal details will be treated as STRICTLY CONFIDENTIAL

Participant

Name:		
Registration No.		
Signature:		Date:
Address:		

Researcher or Representative

Name:		
Signature:		Date:

Witness

Name:		
Signature:		Date: