PATIENT INFORMED CONSENT FORM

for participation in a scientific clinical study

Official Title of the Study:

"Prospective Randomized Single-Blind Study of the Effectiveness of the Superovulation Stimulation Protocol Using hCG Compared to Standard Protocols"

NCT Number: [___] (to be assigned upon registration at ClinicalTrials.gov)
Institution: LTD “EKODNIPRO”
Principal Investigator: Oleksandr Plyh
Date of document – 29.07.2026
This document has been prepared in accordance with GCP ICH E6(R2), WMA Declaration of Helsinki (2013), and applicable regulations.

INFORMED CONSENT

for the use of alternative treatment

I, _____

(surname, first name, patronymic)

date of birth _____ , residing at: _____

(full postal address, phone number)

received information regarding the treatment methods and medicinal products that may be used in the course of providing me with medical care, their side effects,

All my questions have been answered and I have been given sufficient time to consider and make an informed decision regarding my participation in this treatment.

I have been informed that the use of treatment methods and medicinal products with unproven efficacy is possible only upon receipt of my written consent.

I have been informed that I have the right to participate in the discussion of treatment methods and medicinal products, to freely choose treatment methods and medicinal products,

I have been informed that I am obliged to follow the physician's recommendations, to provide complete and truthful information regarding my medical history, to notify

I have been informed of my right to refuse treatment at any time.

I have been informed that the physician involved in my treatment is prohibited from disclosing information regarding the treatment methods and medicinal products that were

I _____

(surname, first name, patronymic)

I give my consent to alternative treatment, based on the comprehensible information I have received about the scientific clinical study of the medicinal product

I give my consent to cooperate with the physician conducting this alternative treatment, and to immediately inform him/her of any deviations in my condition

I have been informed of the specific features of the alternative treatment and the side effects of the treatment methods and medicinal products chosen by me for

By signing this document, I declare that my decision was not made under pressure from the physician, family, or other persons.

I understand that this consent is a legal document and entails legal consequences for me, and that this document is an integral part of the medical record.

I have been informed that I will receive a signed and dated copy of this document.

Participant's full name	*Signature*	*Date (DD.MM.YY)*

Information provided by the physician

Physician's full name	*Signature*	*Date (DD.MM.YY)*