MICHIGAN CENTER FOR SKIN CARE RESEARCH
PARTICIPATING IN A CLINICAL RESERCH STUDY

- Thank you for your interest in a clinical research study through Michigan Center for Skin Care Research. Your participation - provides an opportunity for you to access investigational treatment options before they become widely available; allows you to play an active role in your own healthcare; and provides the sense of satisfaction to help other people who share your condition.

- The role of the site staff is to check your health at the beginning of the clinical study, provide specific instructions and guidance for what to do during the course of the study, watch over your health throughout the study and to make sure that the study protocol is followed.

- Based on your condition, some clinical trials involve more diagnostic tests, visits, or questionnaires than you might not initially expect. These tests, visits and questionnaires help the site staff, and the sponsor of the trial, assure that your health and safety are monitored as well as collect valuable information to help drive the investigational drug to market.

- Subjects in a clinical research study may be asked to elaborate on related health conditions which may make you feel vulnerable. We can assure you all the information obtained during a clinical research study is kept secure and is shared with only those in relation to the sponsor of the clinical study. You as a subject are identified by your initials and a number that is assigned via a computer.

- Your participation is completely voluntary. If you decide to enroll in a study, you are free to leave the trial at any time for any reason.

For more information, please visit:
www.clinicaltrials@skincareresearch.com
or call us at (586) 286-7325

DISEASE: _____

SKIN CARE RESEARCH REGISTRATION FORM

SCR SCREEN #: _____

PATIENT #: _____

MIDWEST PHYSICIAN: _____

Today's Date: _____

PERSONAL DATA

Name: _____ _____ _____
Last First Middle

Address: _____ Apartment # _____

_____
City State Zip

Home #_____ **Work #**_____ **Cell #**_____

Birth Date:_____

Sex at Birth: □Male □ Female Height: _____ Weight:_____

Marital Status: □ Single □ Married □ Widow □ Divorced

Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino □ Other: _____

Race: □ White / Caucasian □ Black / African American □ Asian □ American Indian/ Alaska Native □ Native Hawaiian or other Pacific Islander □ Decline to Respond

HOW DID YOU HEAR ABOUT US? _____

- **Are you currently participating in any research studies?** □ Yes □ No
- **Have you participated in any previous research studies with Skin Care Research?** □ Yes □ No
- **Would you like to receive text messages and emails about future studies?** □ Yes □ No
- **I wish to remain in the Skin Care Research database for future studies:** □ Yes □ No
- **Are you a patient at Midwest Dermatology?** □ Yes □ No

Your Email address: _____

Preferred Method of Contact: □ Phone Call □ Text □ Email

MIDWEST PHYSICIAN: _____

EMERGENCY DATA:

Please list the name and number of someone we can contact in case of emergency:

Name: _____ Phone: _____ Relationship: _____
First, Last

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT OF 1996 (HIPAA):

We may review your database medical records occasionally to determine whether you may be eligible to participate in certain research studies. Only our clinicians, employees or other members of our workforce will review your medical record. None of your protected information will be disclosed to third parties without your specific authorization. We will contact you by email, text message, mail or any other form of recruitment.

I acknowledge that I have received a copy of the Dermatologists of Central States Notice of Privacy: Version - August 25, 2021.

Subject Signature: _____ **Date** ____/____/____

Parent/Guardian Signature: _____ **Date** ____/____/____
(Signature required if subject is less than 18 years of age)

Address (if different than patient's): _____

Home Phone #: _____ **Work Phone #:** _____ **Cell Phone #:** _____

MIDWEST PHYSICIAN: _____

MEDICAL CONDITIONS / SURGICAL HISTORY:

Please list all medical conditions that you have and any surgeries that you have had done with the approximate date.

MEDICAL CONDITION / SURGERY HISTORY	APPROXIMATE DATE

PRESCRIPTION MEDICATIONS / OVER THE COUNTER MEDICATIONS – VITAMINS – SUPPLEMENTS:

Please list all oral, injectable, topical medications, vitamins & supplements.

MEDICATION	REASON FOR TAKING	DOSE	HOW OFTEN?	APPROX. DATE STARTED