WRITTEN CONSENT

Full name of participant:

Acknowledgement

I have read, or had explained to me, and understand the contents of the Community Pharmacy in Health Care Homes Trial Program Information Statement – July 2020.

Consent

I consent to receive the services provided under the Community Pharmacy in Health Care Homes Trial Program and in doing so I consent to the collection, use and/or disclosure of my personal information as outlined in the Information Statement.

I understand that de-identified data will be used to evaluate the program.

I understand that I may be contacted by the Health Care Homes evaluators on behalf of the Department of Health to participate in a survey, interview or focus group in relation to my participation in the Community Pharmacy in Health Care Homes Trial Program. I understand that I do not have to participate in these activities if I do not want to.

Signature of Participant / authorised representative

Date and Time

Full Name of Participant/ authorised representative

If you are signing on behalf of the Participant, please indicate your relationship to the Participant:

☐ Parent, carer, or guardian

☐ Other - specify the applicable number from one of the categories below here: _____

1) *Enduring Guardian, recognised by a relevant State or Territory law*
2) *Enduring Power of Attorney, recognised by a relevant State or Territory law*
3) *A person recognised by a relevant State or Territory law.*