# Clinical Trial Enrollment Form

**Purpose:** This form is used to collect essential participant information to determine eligibility and formally enroll candidates into a clinical research study. Please complete all applicable sections accurately.

## Participant Information

**Full Name:** {fullName}

**Date of Birth:** {dateOfBirth}

**Gender:** {gender}

**Contact Number:** {contactNumber}

**Email Address:** {email}

**Home Address:** {homeAddress}

## Emergency Contact Information

**Contact Name:** {emergencyContactName}

**Relationship to Participant:** {emergencyContactRelationship}

**Phone Number:** {emergencyContactPhone}

## Study Eligibility Criteria Confirmation

**Primary Diagnosis:** {primaryDiagnosis}

**Date of Diagnosis:** {dateOfDiagnosis}

**Meets Inclusion Criteria?** {meetsInclusion}

**Meets Exclusion Criteria?** {meetsExclusion}

## Insurance Information

**Insurance Provider:** {insuranceProvider}

**Policy Number:** {insurancePolicyNumber}

{#hasInsurance}

* Participant has valid insurance coverage.

{/hasInsurance}

{^hasInsurance}

* Participant does not have active insurance coverage.

{/hasInsurance}

## Medical History

{#medicalConditions}

* **{conditionName}:** {conditionDetails}

{/medicalConditions}

## Current Medications

|  |  |  |
| --- | --- | --- |
| **Medication Name** | **Dosage** | **Frequency** |
| {#medications}{medicationName} | {dosage} | {frequency}{/medications} |

## Consent Information

**Consent Form Signed?** {consentSigned}

**Date of Consent:** {dateOfConsent}

**Name of Study Coordinator:** {studyCoordinator}

## Summary Notes

*{summaryNotes}*

## Investigator Approval

**Investigator Name:** {investigatorName}

**Date of Approval:** {investigatorApprovalDate}

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_