**George Washington University**

**Legally Authorized Representative Identification Template Form for Adult Subjects (HRP-582)**

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1. RESEARCH PROTOCOL#:

2. PRINCIPAL INVESTIGATOR:

3. RESEARCH PARTICIPANT’S NAME:

4. NAME AND ADDRESS OF AGENT OR SUBSTITUTE HEALTH CARE DECISION MAKER:

5. Certification of identification of a **health care agent** or a **substitute health care decision maker** who is the legally authorized representative:

* I certify that I have verified that the legally authorized representative of the research subject is a **health care agent**, named above, who has been appointed by the research subject under a written advance directive. I have reviewed the advance directive and determined that it does not prohibit the agent from enrolling the patient/research subject in the study named above. I will place a copy of the advance directive in the research file.

**OR**

* I certify that I have been unable to identify a health care agent appointed by the research subject. I have determined that the legally authorized representative of the patient/research subject is the **substitute health care decision maker**, named above, who is the first available surrogate health care decision maker for the research subject according to the IRB’s Policy: Legally Authorized Representatives, Children, and Guardians (HRP-021). The relationship of the substitute health care decision maker to the research subject is:
* Court appointed guardian, conservator, or intellectual disability advocate, if consent is within the scope of the court’s order (attach copy of court order)
* Spouse or domestic partner
* Parent
* Adult sibling

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Investigator’s Signature Date and Time

6. By signing below, I certify that I am a licensed medical professional, and I have examined this patient and determined that the patient is unable to provide legally effective information consent for the above referenced research study. I have verified the identity of the LAR and the rationale for the selection of the LAR.

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A. NAME OF CERTIFYING PROFESSIONAL AND DEGREE:

DATE AND TIME PATIENT WAS EXAMINED AND DETERMINED TO BE UNABLE TO PROVIDE LEGALLY EFFECTIVE CONSENT:

COMMENTS:

* AFFILIATED WITH RESEARCH STUDY
* UNAFFILIATED WITH RESEARCH STUDY

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Certifying Professional’s Signature Date and Time

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B. NAME OF CERTIFYING PROFESSIONAL AND DEGREE:

DATE AND TIME PATIENT WAS EXAMINED AND DETERMINED TO BE UNABLE TO PROVIDE LEGALLY EFFECTIVE CONSENT:

COMMENTS:

* AFFILIATED WITH RESEARCH STUDY
* UNAFFILIATED WITH RESEARCH STUDY

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Certifying Professional’s Signature Date and Time