The undersigned, (surname, first name) ……………………...................., gives his/her consent to harvesting (donating), storage and use of lymphocytes for allogeneic purposes.

The undersigned confirms that he/she has read this document, has had the opportunity to ask questions and consents to the collection, storage and use of the lymphocytes.

Please tick all the boxes below to indicate agreement.

|  |  |  |
| --- | --- | --- |
| I have understood the information and have received satisfactory answers to my questions. | [ ]  YES | [ ]  NO |
| I know that I will not receive any financial remuneration for donating lymphocytes. | [ ]  YES | [ ]  NO |
| I have been told what lymphocytes are. The purpose and nature of the collection is clear to me. | [ ]  YES | [ ]  NO |
| I have been told how the collection will be carried out. | [ ]  YES | [ ]  NO |
| The risks involved in this type of collection have been discussed with me. | [ ]  YES | [ ]  NO |
| I agree that the doctors will use the discussed harvesting procedure. | [ ]  YES | [ ]  NO |
| I agree that the doctors will use the donated lymphocytes for a donor lymphocyte infusion and possibly store them. | [ ]  YES | [ ]  NO |
| I can inspect the test results, such as HIV. | [ ]  YES | [ ]  NO |
| I know that a proportion of the collected cells may be frozen. This proportion can only be used for later administration to the patient.  | [ ]  YES | [ ]  NO |
| If the patient dies, these donor lymphocytes will be destroyed. | [ ]  YES | [ ]  NO |
| If the doctor in charge does not consider continued storage useful, the remaining stem cells shall be destroyed. I will not be informed about this. | [ ]  YES | [ ]  NO |
| The donor details are recorded in a database. I know that the donor doctor is bound by professional secrecy and that my details will be treated as confidential. | [ ]  YES | [ ]  NO |
| This consent is given voluntarily and deliberately, after being informed. | [ ]  YES | [ ]  NO |
| I know that I can withdraw my consent to this procedure as long as there has been no processing of the lymphocytes and as long as no actions have been taken to prepare the patient for the administration of lymphocytes. | [ ]  YES | [ ]  NO |
| If cells need to be destroyed, I consent to these cells being used for scientific research. I can always change my decision.  | [ ]  YES | [ ]  NO |

I hereby declare that I have read this document and received sufficient information:

[ ]  I have received a copy of the general donor information letter.

[ ]  I have a copy of the information letter about donor expenses and anonymous communication.

[ ]  I have received a copy of this consent form.

***Donor's surname and first name Doctor's surname and first name***

*National register number/Identity card number:*

*Signature Signature*

*Place: Place:*

*Date: Date:*

***Witness's surname and first name***

*Signature*

*Place:*

*Date:*

Completed in 2 originals:

* 1 for the candidate donor
* 1 for the records