CRCNJ
The Cognitive and Research Center
of New Jersey, LLC
Directed by Michelle Papka, Ph.D.

Clinical Trial Eligibility, NOT Medical Care

We conduct clinical trials and you have contacted us/or we have contacted you to inquire about whether you may be an appropriate participant for this research. Please note that during our initial intake with you (whether by phone or in person), we may be conducting cognitive assessments or other medical testing. Our purpose in doing so is SOLELY to determine your eligibility to participate as a subject in a clinical trial. The assessments and other medical testing are NOT being performed for the purposes of diagnosis, treatment or other medical care. You should consult with your healthcare provider(s) for any and all patient care needs, including diagnosis, treatment and other medical care.

I acknowledge the above statement and understand and agree.

_____ _____

Signature of Patient or Legal Guardian Date

_____

Print Name of Patient or Legal Guardian

Main Office/All Correspondence:
195 Mountain Avenue
Springfield, NJ 07081

TheCRCNJ.com
Phone: 973-850-4622
Fax: 973-850-4621

575 Route 28
Building 2, Suite 2108
Raritan, NJ 08869

NJ Psychology License #35SI00381300

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Informed Consent: Authorized Representative(s) In Event of Incapacity (N.J.S.A. 26:14-5 Consent by persons unable to give consent; surrogate consent)

You are permitted to discontinue participation in this clinical trial at any time and for any reason or for no reason. This document identifies "authorized representative(s)" if you become incapable of deciding for yourself whether to continue your clinical trial participation. For example, your authorized representative might be asked, among other things, to act on your behalf in evaluating whether to sign an updated informed consent form that contains new information about an investigational drug used in your clinical trial.

Your representative is permitted to act on your behalf to provide continuing consent only if (1) you do not object to a determination of incapacity and (2) you do not object to the proposed research intervention. Stated another way, your representative will not be able to provide your consent and authorize continued participation if you have expressed dissent or resistance to participation.

Your authorized representative is required to make decisions about participation in accordance with your health care instructions, if any, and other wishes, to the extent known to the authorized representative. If your authorized representative does not have knowledge of any health care instructions or other wishes of you, or if the instructions or wishes do not clearly indicate what decision should be made, your authorized representative is required to make the decision in accordance with your personal values and his or her best estimation of what you would have chosen if you were capable of making a decision. The authorized representative's responsibilities, as stated here, are established by New Jersey statute (N.J.S.A. 26:14-5(a)).

Please state whether you have any of the following and provide contact information as instructed below.

1. Guardian ☐ Yes ☐ No

☐ Check box at left ONLY IF you authorize your guardian to make health care decisions for you

NOTE: Under New Jersey law, for informed consent purposes, a "Guardian" who has authority to make health care decisions for you may be given first priority to act as your Authorized Representative for informed consent purposes. This is true even if you have an advance directive for health care that designates a different person as your Health Care Representative. Under no circumstances, however, shall decisions made in connection with informed consent override an advance directive for health care.

2. Advance directive for health care designating a Health Care Representative

☐ Yes ☐ No

If "yes," **provide us with a copy of your advance directive for health care** and provide us with the full contact information for your Health Care Representative below. If you update your advance directive for health care OR if you do not have an advance directive for health care now, but during this trial you execute one, be sure to provide us with that form so that we may update our records.

If "no" to #1 and #2 above, New Jersey law requires us to obtain surrogate informed consent from any of the following persons in the following descending order of priority.

3. Spouse or civil union partner ☐ Yes ☐ No

4. Domestic partner (as defined in N.J.S.A. 26:8A-3) ☐ Yes ☐ No

5. Adult son(s) or daughter(s) ☐ Yes ☐ No If yes, how many? _____

6. Custodial parent ☐ Yes ☐ No

7. Adult brother(s) or sister(s) ☐ Yes ☐ No If yes, how many? _____

8. Adult grandchild(ren) ☐ Yes ☐ No If yes, how many? _____

9. Other adult relative(s) ☐ Yes ☐ No

If you have less than four individuals who qualify for the categories above, then when providing contact information below for adult representative(s), begin with the closest degree of kinship to you.

Provide contact information below for a total of four individuals meeting criteria for #1-9, beginning with those individuals who meet the criteria for #1, then #2, etc. until contact information for four individuals is provided.

1) Circle category # (per list above): 1 2 3 4 5 6 7 8 9

Name _____ Relationship _____

Street Address _____ City, State & Zip Code _____

Phone Number(s) _____ E-mail Address _____

****

2) Circle category # (per list above): 1 2 3 4 5 6 7 8 9

Name _____ Relationship _____

Street Address _____ City, State & Zip Code _____

Phone Number(s) _____ E-mail Address _____

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3) Circle category # (per list above): 1 2 3 4 5 6 7 8 9

Name _____ Relationship _____

Street Address _____ City, State & Zip Code _____

Phone Number(s) _____ E-mail Address _____

****

4) Circle category # (per list above): 1 2 3 4 5 6 7 8 9

Name _____ Relationship _____

Street Address _____ City, State & Zip Code _____

Phone Number(s) _____ E-mail Address _____

****

The information provided above is true and correct to the best of my ability.

Date _____ Clinical Trial Participant's Signature _____

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Dear Patient,

Thank you for your participation in a clinical trial currently being conducted at our center. Should any new symptoms or conditions arise, or if there is a need to change or add medications, please call us immediately. During the course of the study, we will collaborate with your primary care physician and possibly other specialists you may see regularly. As/if symptoms arise, we may refer you to your PCP for evaluation and treatment of symptoms. In the interest of safety, it is important that you follow up with your PCP as recommended by our study team. We will collaborate with you and your physician so that we may then determine whether or not the symptoms could be related to the study drug and how/if you should proceed in the study.

It is important to note that the study doctor will conduct exams for the sole purpose of assessing general health and potential adverse events that may occur from taking the study medication. Seeing the study doctor does NOT replace the need for you to follow-up with your doctors as you otherwise would. If you do not currently have a PCP, we will be happy to refer you to one.

Primary Care Physician Name: _____

Phone Number: _____ Fax: _____

Address: _____

_____

_____

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List any other specialists below:

Doctor's Name: _____

Specialty: _____

Phone Number: _____ Fax: _____

Address: _____

_____

Doctor's Name: _____

Specialty: _____

Phone Number: _____ Fax: _____

Address: _____

_____

_____

By signing below, we grant permission to CRCNJ to inform the above listed doctors about my participation in the study and to collaborate as needed in the interest of my safety.

Patient Signature: _____ Date_____

Study Partner: _____ Date:_____

Legally Authorized Representative Signature: _____

Date: _____

CRCNJ

The Cognitive and Research Center
of New Jersey, LLC
Directed by Michelle Papka, Ph.D.

SUBJECT NAME: _____

D.O.B.: _____

Please check off your preferred contact method (check off all that apply):

_____ Phone Is it ok to leave a message? _____ YES _____ NO

_____ Email _____ Regular Mail

CONSENT TO COMMUNICATE:

I agree to allow the following individuals to speak directly to the staff at the CRCNJ on my behalf. This information may include, but not limited to: medical history, medications, clinical trial information, and/or study participation. I have been also advised that although CRCNJ's e-mail is on a secure server, that private information sent to my email address may not be secure.

NAME	RELATIONSHIP	PHONE NUMBER	EMAIL ADDRESS

Subject Signature: _____ **Date:** _____

Legally Authorized Representative Signature: _____ **Date:** _____

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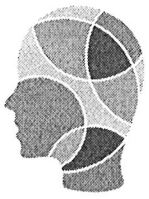

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Medical Release of Information

I, _____ authorize the release of all medical records to The Cognitive and Research Center of New Jersey for the purpose of clinical care and participation in research from the following doctors:

_____

_____

_____

_____

_____ _____

Signature of Patient Date

_____ _____

Print Name of Patient Date of Birth

_____ _____

Signature of Legal Representative Date

_____

Print Name of Legal Representative

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Study ID - _____

Subject Name _____

Address _____

City _____ State _____ Zip Code _____

Home Phone # _____ Cell Phone # _____

DOB _____

Caregiver Name _____

Address _____

City _____ State _____ Zip Code _____

Home Phone # _____ Cell Phone # _____

Relationship to subject _____

Emergency Contact _____

Phone # _____

Relationship to subject _____

Form **W-9**
(Rev. December 2014)
Department of the Treasury
Internal Revenue Service

Request for Taxpayer Identification Number and Certification

Give Form to the requester. Do not send to the IRS.

Print or type
See Specific Instructions on page 2.

1 Name (as shown on your income tax return). Name is required on this line; do not leave this line blank.

2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification; check only **one** of the following seven boxes:

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ _____

Note. For a single-member LLC that is disregarded, do not check LLC; check the appropriate box in the line above for the tax classification of the single-member owner.

☐ Other (see instructions) ▶

4 Exemptions (codes apply only to certain entities, not individuals; see instructions on page 3):

Exempt payee code (if any) _____

Exemption from FATCA reporting code (if any) _____

(Applies to accounts maintained outside the U.S.)

5 Address (number, street, and apt. or suite no.)

Requester's name and address (optional)

6 City, state, and ZIP code

7 List account number(s) here (optional)

Part I Taxpayer Identification Number (TIN)

Enter your TIN in the appropriate box. The TIN provided must match the name given on line 1 to avoid backup withholding. For individuals, this is generally your social security number (SSN). However, for a resident alien, sole proprietor, or disregarded entity, see the Part I instructions on page 3. For other entities, it is your employer identification number (EIN). If you do not have a number, see *How to get a TIN* on page 3.

Note. If the account is in more than one name, see the instructions for line 1 and the chart on page 4 for guidelines on whose number to enter.

Social security number

			–			–				

or

Employer identification number

		–							

Part II Certification

Under penalties of perjury, I certify that:

1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and
2. I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding; and
3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

Sign Here Signature of U.S. person ▶ Date ▶

General Instructions

Section references are to the Internal Revenue Code unless otherwise noted.

Future developments. Information about developments affecting Form W-9 (such as legislation enacted after we release it) is at *www.irs.gov/fw9*.

Purpose of Form

An individual or entity (Form W-9 requester) who is required to file an information return with the IRS must obtain your correct taxpayer identification number (TIN) which may be your social security number (SSN), individual taxpayer identification number (ITIN), adoption taxpayer identification number (ATIN), or employer identification number (EIN), to report on an information return the amount paid to you, or other amount reportable on an information return. Examples of information returns include, but are not limited to, the following:

- Form 1099-INT (interest earned or paid)
- Form 1099-DIV (dividends, including those from stocks or mutual funds)
- Form 1099-MISC (various types of income, prizes, awards, or gross proceeds)
- Form 1099-B (stock or mutual fund sales and certain other transactions by brokers)
- Form 1099-S (proceeds from real estate transactions)
- Form 1099-K (merchant card and third party network transactions)
- Form 1098 (home mortgage interest), 1098-E (student loan interest), 1098-T (tuition)
- Form 1099-C (canceled debt)
- Form 1099-A (acquisition or abandonment of secured property)

Use Form W-9 only if you are a U.S. person (including a resident alien), to provide your correct TIN.

If you do not return Form W-9 to the requester with a TIN, you might be subject to backup withholding. See *What is backup withholding?* on page 2.

By signing the filled-out form, you:

1. Certify that the TIN you are giving is correct (or you are waiting for a number to be issued),
2. Certify that you are not subject to backup withholding, or
3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and
4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.

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(Rev. December 2014)
Department of the Treasury
Internal Revenue Service

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2 Business name/disregarded entity name, if different from above

3 Check appropriate box for federal tax classification; check only **one** of the following seven boxes:

☐ Individual/sole proprietor or single-member LLC ☐ C Corporation ☐ S Corporation ☐ Partnership ☐ Trust/estate

☐ Limited liability company. Enter the tax classification (C=C corporation, S=S corporation, P=partnership) ▶ _____

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☐☐☐ - ☐☐ - ☐☐☐☐

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3. I am a U.S. citizen or other U.S. person (defined below); and
4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct.

Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For real estate transactions, item 2 does not apply. For mortgage interest paid, acquisition or abandonment of secured property, cancellation of debt, contributions to an individual retirement arrangement (IRA), and generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. See the instructions on page 3.

Sign Here | **Signature of U.S. person ▶** | **Date ▶**

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2. Certify that you are not subject to backup withholding, or

3. Claim exemption from backup withholding if you are a U.S. exempt payee. If applicable, you are also certifying that as a U.S. person, your allocable share of any partnership income from a U.S. trade or business is not subject to the withholding tax on foreign partners' share of effectively connected income, and

4. Certify that FATCA code(s) entered on this form (if any) indicating that you are exempt from the FATCA reporting, is correct. See *What is FATCA reporting?* on page 2 for further information.