CINCINNATI CHILDREN'S HOSPITAL MEDICAL CENTER (CCHMC)
INFORMED CONSENT/PARENTAL PERMISSION FORM FOR PARTICIPATION IN A RESEARCH STUDY
Use for adults (≥18 years old) and older teens (15 – 17 years old)

STUDY TITLE: A Study to Validate Blood-Based Methods for the Diagnosis of Pulmonary Alveolar Proteinosis

SPONSOR NAME: Bruce Trapnell, MD **STUDY NUMBER:** RLDN-101 (CCHMC IRB# 2011-0147)

INVESTIGATOR: Bruce Trapnell, MD **TELEPHONE NUMBER**: 513 636-6361

PARTICIPANT NAME: _____ **DATE OF BIRTH**: _____/_____/____ (mm/dd/yy)

You have been asked to volunteer to participate in a research study. You may refuse to participate or withdraw from it at any time without penalty or loss of benefits to which you are otherwise entitled. Before agreeing, it is important that you understand the purpose, procedures, benefits, risks, discomforts, and precautions of the study. Throughout this form, reference will be made to participants, which may be you or your participating child or legal ward, as appropriate.

WHO IS CONDUCTING THE RESEARCH STUDY?
Bruce Trapnell, M.D., a physician at Cincinnati Children's Hospital Medical Center (CCHMC), is responsible for supervising all aspects of the study. The National Institutes of Health (NIH) provided financial support for the study.

WHY IS THIS RESEARCH BEING DONE?
This study will evaluate blood tests to help identify people with Pulmonary Alveolar Proteinosis (PAP).

WHY HAVE YOU BEEN ASKED TO TAKE PART IN THIS RESEARCH STUDY?
This is because you may have PAP, a relative with PAP, or another disease possibly affecting the test; or can serve as a healthy control for the test. Your participation will help determine the accuracy and disease-detecting ability of the test.

WHO SHOULD NOT BE IN THE RESEARCH STUDY?
People with serious infections transmitted by blood, or major medical or psychiatric illnesses are not eligible to participate. Examples of serious infections include but are not limited to viral hepatitis; HIV and Creutzfeldt-Jakob virus.

HOW LONG WILL YOU BE IN THE RESEARCH STUDY?
You will be in the research study for about 2 weeks. The investigator may end your participation at any time, without your permission if (1) this is in your medical best interest, (2) the study ends early, or (3) new information becomes available.

HOW MANY PEOPLE WILL TAKE PART IN THE RESEARCH STUDY?
About 100 people are expected to participate in the study each year at various centers throughout the world.

WHAT IS INVOLVED IN THE RESEARCH STUDY?
Participants will donate blood, answer health-related questions, and provide information about any medical conditions.

The blood sample can be obtained at CCHMC or your doctor's office (or other test center) and sent to CCHMC. Blood will be collected using a routine clinical method. Briefly, a tourniquet may be applied, the skin is wiped with alcohol, and a sterile needle is inserted into a superficial vein and up to 2 tablespoons of blood is withdrawn from adults and less from children and infants. Pressure and a Band-Aid are applied to prevent bleeding. You may be asked to provide a buccal skin sample. In this procedure, the inside of your mouth is wiped with a cotton swab to obtain cells that line your mouth.

We will also collect the following information from you and/or your medical health: (1) past medical history, (2) family history, (3) medical records, including laboratory test results, lung function studies, chest x-rays and CT scan results, physical exam records, hospital records, (4) lung biopsy slides and/or tissue blocks, (5) discarded clinical samples or unused tissue samples. The investigator will keep this information in a confidential file at CCHMC. You will be asked to sign a release of medical information form indicating your approval for your medical information to be sent to us.

If you agree, your left over samples will be numbered and stored in a freezer at CCHMC for use in future research studies conducted to determine what causes PAP, how to diagnose PAP, and to develop better treatments for PAP.

If you agree, you samples will be evaluated for abnormalities in the genes that may cause PAP. Genes are what makes up your chromosomes and transmits traits like blue eyes, brown hair, or certain diseases to children. These results may identify specific abnormalities in your genes that affect the development of PAP or a response to therapy for PAP.

If you agree, the investigator may contact you in the future to ask if you would like to participate in other research studies.

WHAT ARE THE RISKS AND DISCOMFORTS OF THE RESEARCH STUDY?
The risks include minor pain, bleeding and/or bruising where blood is taken or, rarely, scar formation or infection. There may be unknown or unforeseen risks associated with study participation.

ARE THERE DIRECT BENEFITS TO TAKING PART IN THE RESEARCH STUDY?
No direct medical benefits to you are associated with participation. However, knowledge about your disease may be helpful. Also, the information learned may benefit other patients with PAP.

WHAT OTHER CHOICES ARE THERE?
Participation is voluntary and your choice. No certified blood tests are currently available clinically for diagnosis of PAP.

HOW WILL INFORMATION ABOUT YOU BE KEPT PRIVATE AND CONFIDENTIAL?
Precautions will be taken to protect your privacy and the confidentially of your test results and medical information. The Investigator and other CCHMC staff involved in this study will take steps to ensure the confidentiality of your private information, including your name, address, phone numbers, fax numbers, social security number, medical record numbers, and/or any other unique identifying numbers. This information will be available only to the investigator and other staff authorized by the investigator. None of this private information will be included in any publication arising from conduct of the study or use of your samples in any other future study.

If you agree to participate in the study, you will be registered as a research participant of this study in computerized enrollment log maintained at CCHMC.

By signing this consent form, you give permission to inspect all or part of your medical and research records to the following: (1) the Investigator, (2) authorized representatives of the investigator, (3) other CCHMC employees involved in the study including members of the Institutional Review Board (IRB) and Office for Research Compliance and Regulatory Affairs (ORCRA), and (4) officials of the NIH.

A Certificate of Confidentiality from the Department of Health and Human Services (DHHS) is being obtained for this study, preventing the release of any information (for example, if requested by a court order or subpoena) that may identify you in any federal, state, or local civil, criminal, administrative, legislative, or other proceeding. However, disclosure to DHHS staff for audit or program evaluation purposes may be necessary upon their request. A Certificate of Confidentiality does not prevent you from voluntarily releasing information about yourself or your involvement in this research study.

If suspected, the investigator has an ethical and legal obligation to report child abuse or neglect and to help prevent you from carrying out any threats to do serious harm to yourself or others. If keeping your information private would put you or someone else in immediate danger, the investigators would release information to protect you or another person.

WILL THE RESULTS OF MY RESEARCH-RELATED TESTS BE AVAILABILE?
A copy of your test results will be provided to you and your physician, if he/she was requested the test.

WHAT IF NEW INFORMATION BECOMES AVAILABLE DURING THE RESEARCH?
The investigator will provide to you any information that may affect your health, welfare, or willingness to stay in this study.

WHAT ARE YOUR COSTS TO BE IN THIS STUDY?
There are no costs for you to participate in this study. You (or your insurance company) must pay for your routine care.

WILL YOU BE PAID TO PARTICIPATE IN THIS RESEARCH STUDY?
You will not be paid to participate in this study. If a product is developed from use of your samples as a result of this study, there is no plan to provide any financial compensation to you.

WHAT ARE YOUR RIGHTS AS A PARTICIPANT?
Your participation in this study is voluntary. Your decision whether or not to participate will not result in any penalty or loss of benefits to you. The standard medical care for your condition will remain available to you.

If you have questions about the study, you will have a chance to talk to one of the study staff or your regular doctor. Do not sign this form unless you have had the chance to ask questions and have received satisfactory answers.

You have a right to refuse to sign this consent form and Authorization to use/disclose your PHI for research purposes. If you refuse to sign this authorization, your rights concerning treatment not related to this study, payment for services,

enrollment in a health plan or eligibility of benefits will not be affected.

If you decide to take part in the research study, you are free to withdraw your consent and discontinue your participation at any time. You also have the option to remove your samples at any time. However, it is important to know that samples that have already been distributed to researchers prior to your withdrawal will not be destroyed.

Nothing in this consent form waives any legal rights you may have nor does it release the investigator, the sponsor, the institution, or its agents from liability for negligence.

WHO DO YOU CALL IF YOU HAVE QUESTIONS OR PROBLEMS?
For questions, concerns, or complaints about this research study or to report a research-related injury, you can contact Dr. Bruce Trapnell at 513-636-6361**.** Researchers are available to answer any questions you may have about the research at any time.

If you have general questions about your rights as a research participant, or questions, concerns, or complaints about the research, you can call the CCHMC IRB at 513-636-8039. You can also call this number if the research staff could not be reached, or if you wish to talk to someone other than the research staff.

HIPAA AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION FOR A RESEARCH STUDY

We understand that information about you and your health is personal and we are committed to protecting the privacy of that information. Because of our commitment to protect your privacy, we must obtain your written authorization (permission) before we may use or disclose (release) your "protected health information" (sometimes referred to as "PHI") related to the study described to you. This form provides that authorization and helps us make sure that you are properly informed of how this information will be used or disclosed. Please read the information below carefully before signing this form either for you, as the participant, or as the personal representative (parent, legal guardian, etc.) for the participant. Note that when we refer to "you" or "your" throughout this document, we are referring to the participant, even when this form is signed by the participant's personal representative.

USE AND DISCLOSURE COVERED BY THIS AUTHORIZATION

If you sign this document, you give permission to Cincinnati Children's Hospital Medical Center ("Cincinnati Children's") to use or disclose your medical and research information for the purpose of this study. Your PHI that will be used and disclosed in connection with this study consists of:

- Your Cincinnati Children's medical records
- Your research record for this study
- Results of your laboratory tests
- Clinical and research observations made during your participation in the study
- In the event that your medical record contains such information, information concerning HIV testing or the treatment of AIDS or AIDS-related conditions, drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological conditions (but not psychotherapy notes).

WHO WILL DISCLOSE, RECEIVE AND/OR USE THE INFORMATION?

This form authorizes the following to disclose, use and receive your PHI:

- Every research site of the study (including Cincinnati Children's and each site's research staff and medical staff)
- Every health care provider who provides services to you in connection with the study
- Any laboratories and other individuals and organizations that analyze your PHI in connection with the study
- The Sponsor and the people and companies they use to oversee, administer and/or conduct the study
- Federal regulatory agencies, other foreign regulatory agencies, and others as required by law
- The members of the Cincinnati Children's Institutional Review Board and staff of the Office of Research Compliance and Regulatory Affairs
- The Principal Investigator and members of the study's research team
- Data Safety Monitoring Board (if applicable)

By signing this document, you are authorizing Cincinnati Children's to use and/or disclose your PHI for this study. The purpose for the uses and disclosures is to conduct the study explained to you during the informed consent process and to ensure that information relating to the study is available to all parties who may need it for research purposes.

Those persons who receive your information may not be required by Federal privacy laws (such as the Health Insurance Portability and Accountability Act, also known as "HIPAA") to protect it and may share the information with others without your permission, if permitted by laws governing them.

You may revoke (choose to withdraw) this authorization at any time after you have signed it by providing the Principal Investigator (listed on the first page of the informed consent document) with a written statement that you wish to revoke it. Your revocation will be effective immediately and your PHI can no longer be used or disclosed for this study by Cincinnati Children's and the other persons or organizations that are identified above, except to the extent that Cincinnati Children's and/or the other persons or organizations identified above have already acted in reliance on the Authorization. In addition, the information may continue to be used and/or disclosed to preserve the integrity of the study.

Unless you notify us in writing of your decision to withdraw this authorization to use and disclose your PHI, it will expire at the end of the study. If the study involves the creation or maintenance of a research database repository, this authorization will not expire.
If you refuse to sign this authorization, you may not be able to receive research-related procedures and may not be able to continue in this study. However, your rights concerning treatment not related to this study, payment for services, enrollment in a health plan or eligibility of benefits will not be affected.

For further information about your rights, please see the Cincinnati Children's Notice of Privacy Practices on our website at http://www.cincinnatichildrens.org/about/corporate/hipaa.

SIGNATURE PAGE (PARENTAL PERMISSION/INFORMED CONSENT)

When used for adults (>18 years old), the adult should sign as the participant.
When used for older teens (15 – 17 years old), the teen should sign as the participant and their parent or legal guardian should sign as the parent or legally authorized representative.

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SPONSOR NAME: Bruce Trapnell, MD

AGREEMENT TO PERMIT MY SAMPLES TO BE STORED:

I consent to the transfer of ☐ my / ☐ my child's/legal ward's blood, serum, plasma, unused and/or discarded specimens collected for this protocol to the Rare Lung Diseases Tissue and Data Repository (PI: Trapnell, Bruce) at Cincinnati Children's for research purposes.

_____/_____ Yes, I consent
Initials Date

_____/_____ No, I do not consent
Initials Date

AGREEMENT TO PERMIT USE OF MY SAMPLES FOR GENETIC RESEARCH:

I consent to the use of ☐ my / ☐ child's/legal ward's specimens for genetic research.

____/_____ Yes, I consent
Initials Date

_____/_____ No, I do not consent
Initials Date

AGREEMENT TO BE CONTACTED FOR POSSIBLE FUTURE RESEARCH STUDIES:

I consent to future contact by a researcher associated with CCHMC to ask about taking part in more research.

_____/_____ Yes, I consent
Initials Date

_____/_____ No, I do not consent
Initials Date

AGREEMENT TO PARTICIPATE IN THE STUDY:

I have read the information given above. The investigator or his/her designee has personally discussed with me (my participating child or legal ward) the research study and have answered my questions. I am aware that, like in any research, the investigators cannot always predict what may happen or possibly go wrong. I have been given sufficient time to consider if I (my child) should participate in this study. I hereby give consent for ☐ me / ☐ my child/legal ward to take part in this study as a research study subject. I will receive a copy of this signed form for my records.

_____ _____
Participant's Signature Date

_____ _____
Signature of Participant's Parent or Legally Authorized Representative* Date

* If signed by a legally authorized representative, a description of such representative's authority must be provided

_____ _____
Signature of individual obtaining consent Date