APPENDIX H

INFORMED CONSENT FORM

(To be completed by patient / subject)

Date	**:**
Title of research project	**:** A clinical evaluation of hip joint functional ability after sacroiliac joint manipulation in patients with sacroiliac joint syndrome.
Name of supervisor	**:** Dr B. Kruger (M.Tech:Chiropractic, CCSP)
Tel	**:** (031) 5649091
Name of research student	**:** Bruce Turner
Tel	**:** (031) 2042205

Please circle the appropriate answer **YES /NO**

1. Have you read the research information sheet? Yes No
2. Have you had an opportunity to ask questions regarding this study? Yes No
3. Have you received satisfactory answers to your questions? Yes No
4. Have you had an opportunity to discuss this study? Yes No
5. Have you received enough information about this study? Yes No
6. Do you understand the implications of your involvement in this study? Yes No
7. Do you understand that you are free to withdraw from this study? Yes No
   at any time
   without having to give any a reason for withdrawing, and
   without affecting your future health care.
8. Do you agree to voluntarily participate in this study Yes No
9. Who have you spoken to? ____________________________

Please ensure that the researcher completes each section with you
If you have answered NO to any of the above, please obtain the necessary information before signing
Please Print in block letters:

Patient /Subject Name:________________________________Signature: _______

Witness Name:____Signature:_______

Research Student Name:________________________________Signature:_______