**Appendix 2**

CONSENT FORM FOR RESEARCH PARTICIPATION

Project title: Simulation training for Residents and Respiratory Therapist on Mechanical Ventilation using Computer-based Simulation

Investigators:Yasmin Leigh, D.O., Christian De Elia, D.O., Murali Krishna, M.D., LaTanya Taylor, R.T., Rachel Morales, Beth Kellogg, Frank Salvatore.

We are planning to conduct a research study, which I invite you to take part in. I am doing this study in conjunction with my colleagues at Orange Regional Medical Center in Middletown NY. This form has important information about the reason for doing this study, what we will ask you to do throughout the study and upon completion of the research project.

*Why are you doing this study?*

You are being asked to participate in a research study about Simulation based training in mechanical ventilation. The purpose of the study is to to assess the approach of mannequin simulation-based training as a method to provide a more interactive learning experience which may lead to better therapeutic performance in real-life clinical settings

Study time: Study participation will take approximately: 1.5 hours

Study location: All study procedures will take place at Orange Regional Medical Center in the respiratory therapy department

*What are the possible risks or discomforts?*

Participating in mechanical ventilation scenarios involves minimal psychological, social, or other risks. We do not expect any serious adverse events during these non-invasive assessments. Since there are no significant risks associated with the procedures, this study is justified because useful new scientific knowledge will be obtained.

Protection against risk

All pretest and posttest assessments will be completed within an adequate time frame to allow for participants to answer the questions without an mental distress or discomfort.

Dissemination of information: Results of questionnaires as requested will be provided to the participant. Subjects will be advised that the results may be published in a manuscript, but their identities will not be divulged.

To the best of our knowledge, the things you will be doing have no more risk of harm than you would experience in everyday life.

Financial Information

Participation in this study will involve no cost to you. You will not be paid for participating in this study.

*Who can I contact if I have questions or concerns about this research study?*

If you have questions, you are free to ask them now. If you have questions later, you may contact the researchers at ORMC:

Yasmin Leigh DO: phone: 845-467-1421, email: yleigh@ghvhs.org

If you have any questions about your rights as a participant in this research, you can contact the following office at the Orange Regional Medical Center:

ORMC Institutional Review Board

Clinical Trials

707 E. Main St.

Middletown, NY 10940

Phone: (845)-333-1133

Email: jgerlach@ormc.org

Consent

 I have read this form and the research study has been explained to me. I have been given the opportunity to ask questions and my questions have been answered. If I have additional questions, I have been told whom to contact. I agree to participate in the research study described above and will receive a copy of this consent form.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date/Time\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Participant’s Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Participant’s Name (printed)

I hereby certify that I have explained the nature, benefits, risks of, and alternatives to including no treatment and attendant risks, the proposed operation(s) and/or procedure(s). I have offered to answer any questions and have fully answered such questions. I believe that the patient/relative/guardian fully understands what I have explained and answered.
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date/Time\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Physician’s Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name

Witness:
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date/Time\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Witness Signature

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Witness Print Name