

SINGHEALTH INVESTIGATIONAL MEDICINE UNIT

Volunteer Sign Up Form

1.	Name (per ID):	
2.	NRIC/ FIN/ Passport No:	
3.	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female If Female, are you still having menstrual period? <input type="checkbox"/> Yes <input type="checkbox"/> No (Reason for no menstruation: _____)	
4.	Birth Date:	_____ (DD) / _____ (MM) / _____ (YYYY)
5.	Marital Status:	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated
6.	Race:	<input type="checkbox"/> Chinese <input type="checkbox"/> Malay <input type="checkbox"/> Indian <input type="checkbox"/> Others (Please specify: _____)
7.	Contact (HP):	
8.	Email:	
10.	Height (M) / Weight (Kg)	_____ (m) / _____ (kg)
11.	Occupation:	
12.	Last Blood Donation if any	_____ (DD) / _____ (MM) / _____ (YYYY)
13.	Smoking status:	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Quit. Since (MM/YYYY: _____)
14.	Drinking status:	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Quit. Since (MM/YYYY: _____)
15.	Allergy (Drug/Food, etc)	<input type="checkbox"/> No <input type="checkbox"/> Yes (Please specify: _____)
16.	Medical condition (If any)	<input type="checkbox"/> No <input type="checkbox"/> Yes (Please specify: _____)
17.	Any medications/health supplements	<input type="checkbox"/> No <input type="checkbox"/> Yes (Please specify: _____)
18.	Previously diagnosed with:	
	(i) Dengue	<input type="checkbox"/> No <input type="checkbox"/> Yes
	ii) COVID-19	<input type="checkbox"/> No <input type="checkbox"/> Yes
19.	Had COVID-19 Vaccine:	<input type="checkbox"/> No <input type="checkbox"/> Yes (For yes, please complete the table below)
	Approved Vaccine Name:	
	1 st Vaccine Date (DD/MM/YYYY):	
	2 nd Vaccine Date (DD/MM/YYYY):	
20.	Last Clinical Trial Participation if any:	<input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, please complete the table below)
	Trial Title / Type:	
	Last Dose Date:	_____ (DD) / _____ (MM) / _____ (YYYY)
	Trial End Date	_____ (DD) / _____ (MM) / _____ (YYYY)
	Trial Site/ Place:	

Consent Clause: By completing this form with your personal data, you hereby consent to SingHealth IMU may collect, obtain, store and process your personal data (including photo of you taken at SingHealth IMU) for the purpose of considering your participation in clinical trials.

You hereby give your consent to SingHealth IMU to:

- store and process your Personal Data;
- contact you further to collect more information;
- contact you (via email and/or phone call) to provide any suitable trial details and arrange for clinical trial screening if applicable;
- disclose your Personal Data to the relevant governmental authorities or third parties where required by law or for legal purposes.

Yes. I have read, understood and consent to the SingHealth Data Protection Policy, the full version of which is available at www.singhealth.com.sg/pdpa.

(Kindly read through our SingHealth Data Protection Policy followed by indicate on the check box before submitting the new sign-up form)

For the purpose of updating the above data or withdrawal from future participation in clinical trials, you may at any time email to SingHealth IMU at imu@singhealth.com.sg and we will respond to your request.

Date: _____