1. Do you give us permission to collect, store and use tissue samples you donate, as described in the paragraphs above?

   (Please initial either 'Yes' or 'No') _____Yes _____No

(If your answer to 1. is 'no', please sign, date and print your name at the end of the consent form, without answering any further questions, and send it back to us.)

2. Do you give permission for your personal physician or surgeon to let us know when you are going for surgical testing or treatment for asbestos or mesothelioma?

   (Please initial either 'Yes' or 'No') _____Yes _____No

3. Do you give permission for your union to let us know when you are going for surgical testing or treatment for asbestos or mesothelioma?

   (Please initial either 'Yes' or 'No') _____Yes _____No _____Not Applicable

4. Do you give us your permission to contact, in the future, your doctors and/or any medical centers at which you might have been seen for diagnosis or treatment of asbestos-related medical conditions if there are questions you cannot answer about your health, so that we can gather information about your health status?

   (Please initial either 'Yes' or 'No') _____Yes _____No

5. Do you give us permission to collect and store 6 teaspoons of your blood, if there is no spare blood from either the before-surgery or after-surgery blood drawings that are a standard part of your clinical care, or if there is no blood drawn for as part of your standard clinical care?

   (Please initial either 'Yes' or 'No') _____Yes _____No

6. Do you give us your permission to contact you for the purposes of explaining to you any future studies, so that you can be properly informed before you agree or decline to participate in them?

   (Please initial either 'Yes' or 'No') _____Yes _____No

7. If research conducted on your tissues results in genetic findings which are subsequently confirmed by another laboratory and which the Scientific Advisory Committee of the tissue

bank (a body made up of doctors, researchers and organized labor representatives) considers to be of sufficient importance to you for you to be informed, do you wish to be told of the results, if we are permitted to do so by the currently applicable institutional, state and federal regulations?

(Please initial either 'Yes' or 'No') _____Yes _____No

8. In the event of your death, do you grant permission to your family members to have access to your research records from this study, to the extent permitted by regulations and law?

(Please initial either 'Yes' or 'No') _____Yes _____No _____Not Applicable

If you choose to participate in this study, we will need to keep in contact with you, and would like to find out how you are doing once a year, by telephone.

9. Do you give us permission to contact you periodically, to keep in contact with you and to find out how you are doing?

(Please initial either 'Yes' or 'No') _____Yes _____No

10. Do you give us permission to contact your union if we lose contact with you and/or for your union to give us your updated contact information if they become aware of it?

(Please initial either 'Yes' or 'No') _____Yes _____No _____Not Applicable

YOUR RESPONSIBILITIES IF YOU TAKE PART IN THIS RESEARCH:

If you decide to take part in this research tissue bank you will not be responsible for doing anything. However, the tissue bank will be more useful if we can get your spare tissues if you go for testing (for example, biopsy, thoracoscopy) or treatment (for example, surgery) for mesothelioma or lung cancer. For us to do that, we are going to want you to let us know if you go for testing (for example, biopsy, thoracoscopy) or treatment (for example, surgery) for mesothelioma or lung cancer. If you consent to blood collection, you will also need to undergo blood collection.

COSTS OR PAYMENTS THAT MAY RESULT FROM PARTICIPATION:

You will not be paid for participating in this research tissue bank. Being in this research tissue bank will not lead to extra costs to you.

'OSSIBLE BENEFITS:

Signature Block for Capable Adult

Your signature below documents your permission to take part in this research and to the use and disclosure of your protected health information. A signed and dated copy will be given to you.

_______________________________________ ____________________
Signature of subject Date

____
Printed name of subject

Person Explaining Study and Obtaining Consent

_______________________________________ ____________________
Signature of person obtaining consent Date

____
Printed name of person obtaining consent

Witness Section: For use when a witness is required to observe the consent process,, document below (for example, subject is illiterate or visually impaired, or this accompanies a short form consent):

My signature below documents that the information in the consent document and any other written information was accurately explained to, and apparently understood by, the subject, and that consent was freely given by the subject.

_______________________________________ ____________________
Signature of witness to consent process *Date*

____
Printed name of person witnessing consent process

Tissue Bank Contact Information Sheet

We need the following contact information to accompany the consent form for both consent purposes (we need to call {once} to confirm your consent if you were not consented in person) **and** to verify we have your correct address so we can send you an enrollment card.

Contact Information *(please print)*:

Last Name	
First Name	
Date of Birth	
Address	
City, Province and Postal Code	
Phone Number	
Alternate Phone Number (optional)	
Reg. No. (if member)	

Please post the completed consent form and this Contact Information Sheet to:

Professor Andy Todd

Icahn School of Medicine at Mount Sinai

1 Gustave L. Levy Place, MAIL STOP 1057

New York, NY 10029-6574

USA