Research Program Application

Please complete the form below to apply for the VaxDesign Research Program. All fields are required, except where marked otherwise.

First Name	Home Phone	Are you in good health? Y N
Middle Name	Contact or Cell Phone	Have you donated blood before? Y N
Last Name	Birthdate	Have you donated platelets or plasma? Y N
Email	Sex M F	Optional: Please list any allergies.
Street Address	Weigh lbs.	
City Zip , FL	Height feet inches	

Please read and agree to the following before submitting your application.

- I have read and understand the information about the study, its risks, and compensation.
- I understand that this study is voluntary and I do not have to take part in the study.
- If I start a study, I may stop at any time, without reason.
- I understand that my part in the research may stop at any time for any reason.
- I may be asked to stop the study even if I do not want to stop.

I have read and acknowledge the above conditions.

_____ _____

Signature *Date*