



STUDY PARTNER DEMOGRAPHICS

First Name:	Last Name:	Middle Initial:
Address:		
City:	State:	Zip Code:
Main Phone:	Cell Phone No.:	Age:
Email:		
Date of Birth: ____ / ____ / ____		Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Race:	<input type="checkbox"/> Caucasian <input type="checkbox"/> Asian <input type="checkbox"/> Native Hawaiian / Other Pacific Islander <input type="checkbox"/> Black African American <input type="checkbox"/> Native American/Alaska Native <input type="checkbox"/> Other	
Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Other	Native Language:	
Relationship to subject: <input type="checkbox"/> Spouse <input type="checkbox"/> Son/Daughter <input type="checkbox"/> Friend <input type="checkbox"/> Neighbor <input type="checkbox"/> Other		

Study Partner Signature

Date

The above information is true to the best of my knowledge. I authorize K2 Medical Research to collect, review and store my information for future reference. I also authorize to be contacted by a third party that will provide support during my participation with K2 Medical Research to learn more about resources in my area.

Front Desk Initials: _____

Reviewed by (staff initials and date) _____