# The Buffalo Research Registry - REGISTRATION FORM

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| (Please Print) |
| Contact Information |
| **First Name: Last Name: Middle Initial:** |
| **Preferred Name:**  |
| **Street address:** | **P.O. Box:** |
|  |  |
| **City:** | **State:** | **Zip Code:** | **Primary Phone Number:**  |
|  |  |  | ( ) |
| **Secondary Phone Number:** ( ) | **Email Address:**  | **Date of Birth:**  |
| **VOLUNTEER INFORMATION***Remember: You only have to disclose the information you feel comfortable sharing.* |
| **What is/was the sex on your birth certificate?** ❑ Male ❑ Female ❑ Would rather not disclose **Which of the following best describes you?** ❑ Heterosexual (straight) ❑ Gay or Lesbian ❑ Bisexual ❑ Not Sure ❑ Would rather not disclose | **A transgender person is someone whose biological sex at birth does not match the way they think or feel about themselves. Are you transgender?** ❑ No, I am not transgender ❑ Yes, I am transgender and I think of myself as really a man ❑ Yes, I am transgender and I think of myself as really a woman ❑ Yes, I am transgender and I think of myself in some other way ❑ I do not know if I am transgender ❑ I do not know what this question is asking ❑ Would rather not disclose |
| **Are you from a multiple birth (twins, triplets, etc.)?**❑ Yes ❑ No**If yes**, what are you? ❑ Twin ❑ Triplet ❑ Quadruplet ❑ A higher number multiple**If yes**, are you identical? ❑ Yes ❑ No ❑ I’m not sure | **Employment Status:**❑ Student ❑ Employed full time❑ Employed part time❑ Retired❑ Disabled**Veteran Status:** ❑ Veteran ❑ Non-veteran  | **Do you use tobacco?** ❑ Yes ❑ No**Do you drink alcohol?** ❑ Yes ❑ No**Do you use recreational drugs?** ❑ Yes ❑ No |
| **Race:** ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑ Native Hawaiian or other Pacific Islander❑ White ❑ Multi-Racial ❑ Other ❑ Would rather not disclose | **Ethnicity:** ❑ Hispanic or Latino ❑ Not Hispanic or Latino **Were you born outside of the United States?** ❑ Yes ❑ No**If yes,** what is your country of origin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | **Primary Language**❑ English ❑ Spanish❑ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Secondary Language**❑ English ❑ Spanish❑ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| Volunteer Health INFORMATION*Remember: You only have to disclose the information you feel comfortable sharing.*  |
| **Height:** | **Weight:** |  |
|  |  |  |
| **Please share with us any conditions or diseases that you may have. You may enter in as few or as many conditions as you like.** |
| **Please list any medications or over-the counter drugs/products that you are currently taking that you would like to have as a part of your profile:**   |
|  |  |  |  |  |  |
| **How far would you be willing to travel to participate in research studies?** ❑ less than 10 miles ❑ less than 25 miles ❑ less than 50 miles❑ less than 100 miles ❑ It doesn’t matter  |
| **INTEREST IN BEING INFORMED** | **I would like to be contacted about studies related to being a parent:** ❑ Yes ❑ No |
| **I would like to be considered for participation in other areas of research such as:**❑ Giving feedback to researchers on their research studies (i.e. Advisory Boards, Focus Groups)  ❑ Helping promote research studies (i.e. recruit more community members to get involved)  ❑ Talking with other community members about research  ❑ Hearing more about the Patient Voices Network whose vision is to create “a community of educated and involved patients working hand in hand with physicians in making decisions about their own health care.”**I would like to receive information on:**❑ Community presentations on research happening at UB ❑ Community events i.e. health fairs, walks, etc. ❑ Trainings for community members who would like to learn more about research skills |
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I acknowledge that by signing this document that the information I have provided will be added to a registry at the University at Buffalo where researchers can search for volunteers in research studies. That my information will be included in the registry indefinitely unless I contact the Community Engagement Team to withdraw my information at 716-829-2502. They have my permission to contact me if they believe I am a possible match for their study. My signature on this form does not promise my participation in any study it simply acknowledges my willingness to be contacted to be given more information about a study which I will use to decide if I am interested in participating. I understand that there is no guaranteed benefit to being in the Buffalo Research Registry and that participation in the registry is voluntary. The information in this registry will be stored in password protected files on the SMBS cloud server. Hard copies will be stored in a locked file cabinet in the Clinical and Translational Research Center.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



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