Dr A. Jacovides Clinical Trials

Participant Application Form

Full Names
Date of Birth:
GPs name:
Contact Details:
• Mobile
• Landline
• Email address
• Alternate contact numbers:
Known allergies:
Do you smoke? ☐YES ☐ NO
Have you ever tested positive for COVID-19?
Have you been vaccinated for COVID-19?
Have you ever had or currently have any of the following (tick all that apply)?
☐Heart attack ☐Angina
☐Cardiac Stents ☐ Stroke
☐High Cholesterol ☐High blood pressure
☐Diabetes ☐Asthma
☐Heart failure ☐Kidney failure
☐Emphysema ☐Pneumonia
☐Arthritis ☐ Poor circulation
☐Other
Are you interested in potentially participating in a clinical trial?
☐ YES ☐ NO
Which area would be of interest to you (please base your answer on what is potentially applicable to you): _____

PLEASE COMPLETE AND EMAIL BACK TO clinicaltrials@midrandmedicalcentre.co.za