**WAIVER OF CONSENT**

**Name of the Candidate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of the Department: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Title of the Project: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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Itis not feasible to obtain individual informed consent of study participants in this study. Hence, I request you to waive the requirement of obtaining individual informed consent.

I shall be using extracted teeth/archival tissue (whichever applicable) for the above research. I declare that upon completion of my study the extracted teeth/archival tissue shall be disposed off appropriately. I shall be using the extracted teeth/archival tissue/patient records (whichever applicable) only for above research and will not use for any other purpose like stem cell research or genetic typing etc.

However, I assure you that the confidentiality of the information will be ensured and no identifying information related to the study participants will be disclosed in any report/publication arising from the study.

I request you to grant me waiver of consent.

Signature of student Signature of Guide

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_