**ARTP Spirometry Qualification**

**Patient Consent Form**

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

As a participant in the ARTP Spirometry Qualification, I consent to being video recorded for the purpose of examination review by an ARTP assessor.

I understand that:

* The recording may be used to ensure quality assurance in the assessment process.
* The footage may also be utilized for training purposes to enhance assessor development and improve future examinations.
* My participation is voluntary, and I may withdraw my consent at any time before the assessment takes place.

“Patient” Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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