Please read the following information carefully and ask any questions you may have

What is chlorine dioxide in aqueous solution (CDS)?

CDS is a concentrated 0.3% (3000 ppm), aqueous solution of gaseous chlorine dioxide that does not contain sodium chlorite (NaClO2) and has a neutral pH.

More information: https://andreaskalcker.com/EN/cds-clo2/que-es-cds.html

How is the preparation carried out?

1. **Preparation**

   Dilute 10 ml of CDS in 1 liter of drinking water to obtain a proportion of 0.003% (30 ppm). Store tightly closed in the refrigerator in a bottle containing no metal parts.

2. **Dosage**

   Drink 100 ml every hour, until completing 10 doses.

You should wait 1 hour before drinking the next dose. The objective is to drink 1 liter of the preparation per day.

More information: https://andreaskalcker.com/en/cds-clo2/protocolos-cds.html

General known risks

- Massive inhalation of Chlorine Dioxide gas may cause irritation and breathing problems and should be avoided.
- No known adverse endocrinological effects, associated with ingestion of Chlorine Dioxide (CDS) in humans.
- There are no known immunological or lymphatic adverse effects documented from ingestion of chlorine dioxide (CDS) in humans.
- No known neurological adverse effects associated with ingestion of chlorine dioxide (CDS) in humans.
- No known adverse effects on the reproductive tract from ingestion of chlorine dioxide (CDS) in humans.
- No known adverse carcinogenic effects.
- No known mutagenic adverse effects.
- No known adverse effects from accumulation of chlorine dioxide in the form of CDS in humans are known.

More information: https://andreaskalcker.com/en/cds-clo2/toxicidad-del-cds.html
More information on clinical trials carried out with CDS: https://andreaskalcker.com/en/coronavirus/ensayos-cl%C3%ADnicos.html

Specific risks based on your disease situation
(Annotations from the health professional)

Full Name Signature of Patient / Representative / Legal Guardian _____

1. PATIENT DATA

Registration No.:

FIRST NAME	*MIDDLE NAME*	*LAST NAME (S)*	*DATE OF BIRTH*	
ADDRESS	*APT/ SUITE/ FLOOR*		*SEX*	*AGE*
CITY	*STATE*	*ZIP CODE*	*COUNTRY*	
IDENTIFICATION (ID CARD / PASSPORT)	*TELEPHONE 1*	*TELEPHONE 2*	*EMAIL*	

2. LEGAL REPRESENTATIVE OR GUARDIAN DATA

FIRST NAME	*LAST NAME (S)*	*ID CARD / PASSPORT*	*DATE OF BIRTH*

3. WITNESS DATA (1)

FIRST NAME	*LAST NAME (S)*	*ID CARD / PASSPORT*	*DATE OF BIRTH*

4. WITNESS DATA (2)

FIRST NAME	*LAST NAME (S)*	*ID CARD / PASSPORT*	*DATE OF BIRTH*

5. HEALTH PROFESSIONAL DATA

FIRST NAME	*LAST NAME (S)*	*PROFESSIONAL SPECIALTY*
NAME & ADDRESS OF HOSPITAL / CLINIC / OFFICE		*MEDICAL LICENSE # / COUNTRY & STATE ISSUED*

I DECLARE:

a) Being of sound mind and fully aware of my decisions, I hereby grant on my own initiative and decision, my consent to the health professional indicated above in section 5, for the use of chlorine dioxide in the form of CDS, in accordance with current legislation and in compliance with the 2013 protocols of the WMA (World Medical Association) Declaration of Helsinki.

b) I am considered a palliative patient without a cure or treatment for my illness through conventional medicine. I have been searching on my own for an alternative self-help treatment, which is not yet officially approved as a medicine by the institutions in my country of residence.

c) I ask the health professional mentioned above in section 5 to accompany me as a personal consultant in my self-treatment for reasons of safety and consultation of appropriate dosage.

d) **Therapeutic Action.** I understand that chlorine dioxide in the form of CDS (chlorine dioxide in aqueous solution) is used for therapeutic purposes to treat my diagnosis of:

.....

e) I have been duly informed by the health professional mentioned in section 5 above about the possible benefits and risks associated with the use of CDS, including information about possible side effects such as nausea, diarrhea, fatigue, and headache, among others.

f) I understand that the use of CDS is a personal decision and that my consent is voluntary. I have had the opportunity to ask questions and clarify any doubts I may have before making this decision and at the same time I have informed myself of the scientific studies in humans in this regard.

g) I am aware that there are other treatment alternatives available and I have had the opportunity to discuss and consider these options with my health professional. I have decided to use CDS as part of my treatment plan, which is not yet approved as a medication, based on my own research and evaluation of the information provided.

Full Name Signature of Patient / Representative / Legal Guardian _____

h) I agree to assume responsibility for reporting to my health professional any symptoms or adverse effects that I may experience while using CDS. I understand the importance of communicating in a timely manner any changes in my health condition so that my health professional can evaluate and adjust my treatment accordingly.

i) I understand that this consent may be revoked at any time, and I have the right to seek a second medical opinion prior to initiating treatment with chlorine dioxide in the form of CDS. I acknowledge that I have the responsibility to inform my health professional if I decide to discontinue or modify my treatment.

j) I agree to follow all directions and recommendations provided by my health professional regarding the use of chlorine dioxide in the form of CDS. This includes proper dosage, frequency of administration and any other advice related to the safe and effective use of this compound.

k) The results will be used for research purposes and possible medical publications.

In accordance with universal ethical principles:

The health professional: .....

further informs you that he/she accepts the request because:

- Welfare is our primary concern and thus fulfills its Hippocratic oath.
- The data and results obtained will be used for educational purposes.

I have read and understood the information provided. All my questions and doubts have been clarified. I hereby give my voluntary consent to participate in this study/treatment and waive any type of action or complaint, whether civil, criminal or administrative, against the above-mentioned health professional.

(PLACE) ..... *(DATE)* .....

FULL NAME OF PATIENT / REPRESENTATIVE / LEGAL GUARDIAN (*) *(*) ATTACH COPY OF ID* *(NAMES MUST MATCH)* *SIGNATURE:*	*FULL NAME OF HEALTH PROFESSIONAL* *SIGNATURE:*
FULL NAME OF WITNESS (1) *SIGNATURE:*	*FULL NAME OF WITNESS (2)* *SIGNATURE:*

6. REVOCATION OF THE DECLARATION OF INFORMATION AND CONSENT

☐ I revoke my consent to continue with the procedure of the use of chlorine dioxide in the form of CDS, on date: .....

☐ I revoke my consent to the use of the results for research purposes and possible medical publications, on date: .....

FULL NAME OF PATIENT / REPRESENTATIVE / LEGAL GUARDIAN *SIGNATURE:*	*FULL NAME OF HEALTH PROFESSIONAL* *SIGNATURE:*
FULL NAME OF WITNESS (1) *SIGNATURE:*	*FULL NAME OF WITNESS (2)* *SIGNATURE:*

DELETE PRINT