THE UNIVERSITY OF MISSISSIPPI MEDICAL CENTER

Participant Reimbursement Request

(Place completed forms in a Confidential Envelope and route directly to Office of Sponsored Programs – Post-Award for processing)

I. Study information

Date of Request: __ __ / __ __ /__ __			
Study Name/Title:			
Participant Name:	**Participant Number or Reference (required):**		
Accounting Unit:	**Account: 62705**	**Activity Number:**	**Amount:**
Accounting Unit:	**Account: 62705**	**Activity Number:**	**Amount:**
Accounting Unit:	**Account: 62775(Travel)**	**Activity Number:**	**Amount:**
Principal Investigator Name:			
Department Name:			

II. Participant and Payment Information:

Date(s) of Participation: __ __/__ __/__ __, __ __/__ __/__ __, __ __/__ __/__ __, __ __/__ __/__ __

I will receive $_____ for my participation in the study listed above. A check will be issued by the University of Mississippi Medical Center and will be mailed directly to the address listed below in approximately four (4) weeks.

_____ __ __/__ __/ __ __ __ / __ __ / __ __ __ __

Printed Name of Participant Date **Social Security Number of Participant**

_____ __ __ __ / __ __ / __ __ __ __

Signature of Participant **or** Parent/Guardian) **Social Security Number of Parent/Guardian If Needed**

Make check payable and Mail Check to:

(Check must be payable to participant unless minor or legal guardian)

UMMC Employee/Student? YES ____NO____

If yes, fill in Employee/Student # _____

_____

Name

_____ **Apt#, Lot#, Suite# Unit#, Other** _____

Street Address or Post Office Box

_____ _____ _____

City State Zip Code

III. Certification

I certify that the above named person has participated in the research project named as described above.

_____ _____ __ __/__ __/__ __

Signature of Principal Investigator or Designee Printed Name of Principal Investigator or Designee Date

For Accounting Department Use Only:

Vendor Number **AP Review_____/_____**

EXP/EMP **TAX ID** **70** **N1** **Update _____/_____**

Grants Approval: _____

Revised January 2017