College of Health Sciences

RESEARCH PARTICIPANT COMPENSATION FORM

PLEASE PRINT CLEARLY

PARTICIPANT'S INFORMATION

First Name:_____ **Last Name:**_____ **Phone:**_____

Street:_____ **Citizenship:** ☐ U.S. citizen

City:_____ **State:**_____ **Zip:**_____ ☐ Permanent resident (UD W-8 required)

Email:_____ ☐ Non-resident (UD W-8 required)

UD AFFILIATION

If current employee, select one: ☐ Graduate student ☐ Undergraduate student ☐ Other

ID #:_____ **Department:**_____ **HR Liaison:**_____

☐ Past UD employee

☐ Never employed by UD

STUDY DATES AND COMPENSATION INFORMATION

Session Date	Compensation
TOTAL	

Grant/Study Title:_____

_____

_____

Purpose Code:_____

Account Code: 149250

Preferred Payment Method:

☐ Gift card (vendor):_____

Card #:_____

☐ Payment by check

For business office use:

*Req ID:*_____

AUTHORIZATION

Submitted by:_____ _____ _____

PRINT NAME SIGNATURE DATE

Supervisor/PI:_____ _____ _____

PRINT NAME SIGNATURE DATE

✂ **(Cut here)**

IMPORTANT: If the SSN is collected, study personnel **must remove and shred** this section after submission to the departmental business office. **Do not retain the SSN in the study records**. Departmental business office **must remove and shred** this section before forwarding to grants administration.

Social Security #: _____-___-_____ (required for payment by check for non-UD employees or inactive UD employees)