

Subject Payment Request

Name of Participant: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Phone Number: \_\_\_\_\_ Amount to be paid:

\_\_\_\_\_

Please indicate appropriate distribution of payment:

\_\_\_\_\_ Mail to home address

\_\_\_\_\_ Will be picked up from Research Office

\_\_\_\_\_ Forward to Investigator's Office

Indicate IMR account: \_\_\_\_\_

Please reimburse the research participant as indicated, for participation in the \_\_\_\_\_  
Study. Participation will directly or indirectly support research.

\_\_\_\_\_

Signature of Principal Investigator

\_\_\_\_\_

Date

My signature above confirms that a valid HIPAA Authorization (or IRB-approved waiver of authorization) is on file for the patient named above.