



# SUBJECT COMPENSATION FORM

### TO BE COMPLETED BY STUDY PARTICIPANT:

**Participant Name:** \_\_\_\_\_

Social Security Number:    -    -    -

Email: (needed only if using gift certificate/card) \_\_\_\_\_

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

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Home Phone: (    )    -    -    -

Work Phone: (    )    -    -    -

Ext: \_\_\_\_\_

1. Are you currently a VMRF employee?  Yes     No  
 If yes, do not pay, please contact VMRF Accounting for further instructions.
2. Are you currently a VA employee?  Yes     No  
 If you are currently a VA employee, please answer the following questions:
  - a. The activities associated with this research study for which I am volunteering as a study participant are unrelated to my official VA duties:  Yes     No
  - b. I am a member of the VA Research & Development Committee, Independent Review Committee, or the IRB:  Yes     No
  - c. At the time of my volunteering as a study participant I was on off duty status (annual leave or outside of normal VA duty hours).  Yes     No

Participant Signature\*: \_\_\_\_\_ Date: \_\_\_\_\_

*\*Your signature confirms that you understand the number of qualifying visits, the pro-rated dollar amount per visit and the total compensation due to you. Please be aware that the IRS requires VMRF to report to them compensation of \$600.00 or more in a calendar year. In addition, my signature above confirms that my participation in this research study is entirely voluntary.*

### TO BE COMPLETED BY STUDY PERSONNEL:

IRB Protocol No: \_\_\_\_\_

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

Patient Study Status: Initial Visit  Follow-Up  Visit Completed   
 Early Termination  Baseline Failure

Number of Qualifying Visits: \_\_\_\_\_

Amount Per Visit: \$ \_\_\_\_\_

Total Compensation: \$ \_\_\_\_\_

- Check** (preferred method)                       **Cash** (must have prior VMRF approval)
- Gift Certificate/Card** (must have prior VMRF approval)
- Hold Check and Notify Coordinator for Pickup**                       **Mail Check**

### TO BE COMPLETED BY STUDY COORDINATOR:

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

Initials: \_\_\_\_\_

Coordinator Name: \_\_\_\_\_

Extension: \_\_\_\_\_

Principal Investigator: \_\_\_\_\_

VMRF Project # \_\_\_\_\_

Sponsor: \_\_\_\_\_

**Payment Authorized By** (signature): \_\_\_\_\_

*(Below for Accounting Department Use only)*

Requires Contracts Coordinator approval	Initials: _____	Date: _____
Requires C&G approval <input type="checkbox"/> Yes <input type="checkbox"/> No	Initials: _____	Date: _____