Research Subject/Donor ClinCard Acknowledgment Form

Participant/Donor Section (Information in this section remains confidential and will be used only for payment and IRS requirements)

Participant First Name: _____ Participant Last Name: _____

Street Address: _____

City and State: _____

Zip Code: _____ Contact Telephone(s): _____

Email Address: _____ DOB: _____

Social Security Number / Individual Taxpayer Identification Number (SSN/ITIN)*

*Required to receive study payments: SSN/ITIN: _____

If obtaining the SSN/ITIN of a parent/Legal Authorized Representative (LAR), please indicate the name of the LAR below:

LAR First Name: _____ LAR Last Name: _____

☐ **ClinCard Stipend Disbursement**:

Disbursed by (signature/BCM ID#): _____

ClinCard # _____

Would participant like to be notified via cell phone or email when funds are loaded onto ClinCard? ☐ Yes ☐ No

Subject/Donor Signature (only required for issuance of ClinCard) _____

(The signature above certifies that I have received a BCM ClinCard and that I understand that funding of such card may take 48-72 hours)

My signatures below certify that I have participated in this study visit and that I am due compensation as indicated in the amount below.

Research Study Information:	
Protocol Number:	H-
Fund Center:	
Patient ID#:	
DOB:	

Visit	Date	Amount of Stipend	Participant Signature

Visit	Date	Amount of Stipend	Participant Signature

Baylor College of Medicine

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