Institute for Medical Research, Inc.

Honoring our Veterans through innovative medicine.

Subject Payment Request

Name of Participant: _____

If new 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 study 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.

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