EMORY UNIVERSITY

DEPARTMENT OF PEDIATRICS

PATIENT STIPEND FUNDS
GIFT CARDS
NEW OR INCREASE REQUEST FORM

ONLY USE THIS FORM if this fund will be used for participant payments (time, travel, meals) for participation in CLINICAL TRIALS OR RESEARCH PROJECTS USING GIFT CARDS. Email the completed **form with all custodian and PI signatures** to DOPstipends@emory.edu

SIGNATURES/AUTHORIZATIONS - All Applicants Complete this Section

TYPE OF REQUEST	REQUIRED SIGNATURES / APPROVALS
☐ **New GIFT CARD Account Change in Custodian**	All Custodians, Principal Investigator (PI), DOP Research Administration, Department
☐ **Increase GIFT CARD Fund Limit**	All Custodians, Principal Investigator, DOP Research Administration, Department
Required Documentation	**ENOA ; Current IRB Approval letter ; IRB Approved Informed Consent**

Current GIFT CARD Fund Limit (zero if new) _____ Date _____

Contact Person _____ Phone _____ Email _____

Department Requesting GIFT CARDS _____

Type of Gift Card _____ Denomination _____ Plastic or Electronic? _____

Physical Location of Study _____

Does this department have other GIFT CARDS at this location? ☐ No ☐ Yes

Are either of the custodians responsible for other GIFT CARDS? ☐ No ☐ Yes

Award ID	Project ID	IRB Number	Department ID	Account Code
				68715

PARTICIPANT PAYMENTS	
A - TOTAL Gift Card dollar amount Paid to Single Participant	
ESTIMATED FUNDING INFORMATION	
B - Estimated Total Participant Visits Per Month	
C – Gift Card dollar Amount Paid Per Visit (Give range if amounts vary.)	
D - Estimated Dollar Amount in gift cards Paid Per Month	

Estimated Funding Definitions & Formula
A – This is the total dollar amount of gift cards paid to each participant if all study visits are completed and/or requirements met.
B – This is the expected number of participant gift card payments each month due to a visit or other action. (If the same participant will be paid twice in a month that counts as 2 visits.)
C –Dollar Amount of gift cards aid to each participant for each study visit and/or requirement met and should agree to the informed consent.
D = B x C
We understand that these are estimates and that study participation may vary month to month.

***Note: Gift card** limits are set for 2-3 week replenishment.*

Brief Study Title _____ Smartkey _____

Sponsor/Funding Source Name _____

Award Begin Date _____ Award End Date _____

Please describe in detail how the gift cards will be secured.

_____

_____

_____

Please describe the reason an increase in gift cards d limit is needed and amount of increase requested.

_____

_____

_____

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By signing this form, I attest the information contained herein is true and accurate and this fund will be operated in accordance with Emory University Finance guidelines and polices AND the Department of Pediatrics policies and additional guidelines. I understand that failure to adhere to the Research Participant Payment Fund Policy & Procedures and/or the department of Pediatrics policies and guidelines can result in account suspension and/or revocation. ***I understand that improper or fraudulent use of this fund may result in disciplinary action up to and including termination of my employment.***

Note: Custodians must be Emory Employees. Custodians cannot be students, consultants, or temporary employees.

Custodian 1: _____ NAME (please print) _____ SIGNATURE | EMPLOYEE ID# | | | | | | | |

_____ PHONE NUMBER _____ EMAIL ADDRESS _____ DATE

Custodian 2: _____ NAME (please print) _____ SIGNATURE | EMPLOYEE ID# | | | | | | | |

_____ PHONE NUMBER _____ EMAIL ADDRESS _____ DATE

Alternate Custodian 1: _____ NAME (please print) _____ SIGNATURE | EMPLOYEE ID# | | | | | | | |

_____ PHONE NUMBER _____ EMAIL ADDRESS _____ DATE

Alternate Custodian 2: _____ NAME (please print) _____ SIGNATURE | EMPLOYEE ID# | | | | | | | |

_____ PHONE NUMBER _____ EMAIL ADDRESS _____ DATE

Principal Investigator: _____ NAME (please print) _____ SIGNATURE _____ DATE

Research Administration: _____ NAME (please print) _____ SIGNATURE _____ DATE

Department approval: _____ NAME (please print) _____ SIGNATURE _____ DATE