UNIVERSITY OF CALIFORNIA, IRVINE

Department Name _____
Program Name _____
Building location _____
Irvine, CA 92868- Zot #_____
Phone number _____

Principal Investigator Name:_____

Acknowledgement of Patient Compensation

This document is to inform you that patient compensation exceeding $599.99 annually may result in:

a) Your name, address, and social security number being released to the University of California, Irvine Accounting office.
b) The receipt of a 1099 taxable income form from the University of California, Irvine.
c) Alteration of your current entitlements benefits package.

I have read and discussed the above information with the study personnel and have been given the opportunity to ask questions and receive answers. I acknowledge that I waive my confidentiality rights if my annual patient compensation exceeds $599.99.

_____ _____
Signature of Subject or Authorized Legal Representative Date

_____
Print Name of Subject or Authorized Legal Representative

_____ _____
Signature of Witness Date

Subject SS#:_____

Address:_____

City:_____ Zip Code:_____