**ClinCard Participant Information Form (CPIF)**

 **New Participant** [ ]  **Update Participant** [ ]  **Replace Card**[ ]

Study Title:

Site Coordinator Name:

**Participant Instructions:** Please complete the following fields, check off the applicable boxes and sign if you agree to the attestations provided below.

**Name:**

**Address:**

**Home Phone**: ( ) - **Cell Phone:** ( ) - **Date of Birth:** / /

**Tax ID\*:** **E-Mail:**

[\*Required if cumulative participant payments are

expected to be > $400 in current calendar year]

*Tax Identification Number (Social Security Number “SSN” or Individual Taxpayer Identification Number “ITIN”) is used for 1099-MISC tax reporting purposes only. No study specific information is shared with or sent to the IRS.*

**Attestations:**

[ ]  **(Substitute for W-9) If Tax ID required, I certify, under penalties of perjury, that:**

1. My Tax Identification Number (TIN) I have provided is correct,

2. I am not subject to backup withholding due to failure to report interest and dividend income,

3. I am a U.S. person, and

4. I am exempt from FATCA reporting.

[ ]  **I have received my ClinCard**

**Note:** Boxes 1 (if required) and 2 must be check marked, and this form signed, in order to receive compensation for this study (the ClinCard shall not be loaded until the participant indicates receipt of the card).

**Optional:**

[ ]  **I would like to receive payment confirmations and appointment reminders by E-mail**

[ ]  **I would like to receive payment confirmations and appointment reminders by Text Message**

**Sign and Date:**

*The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding*

Participant Date / /

Site Coordinator Date / /