# 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 OR have been informed that my ClinCard will be received via mail

**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:** If signing electronically, instructions are available here to assist.

*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 _____

Study Team: Delete/shred this document once information is entered into ClinCard