|  |
| --- |
| **Departmental Information** |
| Requesting Department Name: |
| Requesting Department Number: |
| Requester Name: |
| Requester Phone: |
| Will Study Participant be Entitled to Expense Reimbursement? |
| **ADDITIONAL NOTES:** |

|  |  |
| --- | --- |
| **Study Participant Information** | |
| * + **The following should ONLY be completed for study participants**   + Attach W-9\* or W-8BEN\*\* for foreign status individuals, if applicable   + Submit to Accounts Payable through email at: [askAP@wakehealth.edu](mailto:askAP@wakehealth.edu) | |
| Participant’s Last Name: | |
| Participant’s First Name and Middle Initial: | |
| Remit to Street Address: | |
| City, State, Zip Code: | |
| Participant’s Social Security #: | |
| **Type of Reimbursement: Mileage Reimbursement  Other Expense Reimbursement Study Participation Reimbursement** | |

\*To obtain blank W-9 form: <http://www.irs.gov/pub/irs-pdf/fw9.pdf>

\*\*To obtain blank W-8BEN form: <https://www.irs.gov/pub/irs-pdf/fw8ben.pdf>

**For efficient processing of New Vendor Request Forms, please start the subject line as “New Vendor SP”**