|  |
| --- |
| **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
 |
| 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”**