NF/SG VHS Research Service Patient Participation Payment Voucher

DATE:

NAME OF PARTICIPANT:

MAILING ADDRESS:

Participant SS#:

<u>COUNTY:</u>

The above individual is a participant in Dr.   ’s research project:

And therefore, eligible for an inconvenience payment in the amount of $

for Visit

CERTIFICATION INFORMATION

The articles or services listed above in the amount of $ have been received.

____

Signature of Certifying official   Date

PRINTED Name & Title of Certifying Official   ext.

Patient Signature ____

Obligation Number:
Control Point:
Transaction #:
PI name and contact person:

22AUG2023_JV