National Cancer Institute
Central IRB Initiative

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OMB#: 0925 – xxxx **Expiry Date: xx/xx/xxxx**

STATEMENT OF CONFIDENTIALITY:

Collection of this information is authorized under 42 USC 285a. Your participation is completely voluntary. You are subject to no penalty if you choose not to provide all or any part of the requested information. Under the provisions of Section 301d of the Public Health Service Act, no information that could permit identification of a participating individual may be released. All such information will be kept private under the Privacy Act and will be presented only in statistical or summary form.

NOTIFICATION TO RESPONDENT OF ESTIMATED BURDEN:

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. **An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number.** Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-xxxx*). Do not return the completed form to this address.

Attachment 4:

DIRECT DEPOSIT FORM - Expense Reimbursements Consultant Payments

Employee/Consultant Name			
	Bank Name		**Check one:** ___ Checking ___ Savings
	Account #		
	Bank Routing #	__ __ __ __ __ __ __ __ __	

In lieu of a live check for payment of expense reimbursements or other amounts due me, I hereby authorize the EMMES Corporation to deposit remittances to the above specified Financial Institution and account.

Signature: _____ **Date:** _____

EMMES Approval: _____ **Date:** _____