

INSTRUCTIONS FOR COMPLETING THE CLINICAL INCOME PAYMENT FORM

Complete all sections of the form. **Forms not filled out completely will be returned to the Department.**

Prepared By: Please include all the information in this box. If there are any questions or missing information on the Clinical Income Payment form, this is who will be contacted. Omitting this information will cause delays in processing the form.

Payment:

- A.** *Employee Name:* Enter the employee's name.
- B.** *Department Name:* Enter the department initiating the form for payment.
- C.** *Org ID:* Enter the department/organization ID number for the department initiating the payment.
- D.** *Employee ID #:* Enter the employee's ID number. (This number must be identical to the number on the PAN.)
- I.** *Amount:* Enter the gross amount to be paid. Hours or rates per hour are not appropriate for clinical incentive.
- J.** *Pay Period Dates:* Enter the starting and ending dates of the pay period for which payment is to be made. Clinical Income payments may not be paid over more than one pay period.
- K.** *Chartfield:* Enter the Chartfield to be charged for these earnings.
 - BU** - Business Unit
 - Org ID** - Organization/Department ID
 - Activity/Project** - Activity or Project Number
 - Account** - 52400-52418
 - A/U** - Allowable (1), Unallowable (0)

Approval:

A department authorized signature is required for payment

This form is due to the Payroll Department, 420 Wakara, no later than 5:00pm the last day of the pay period.

Revised 08/01/06

**University of Utah Payroll Department
Medical Practice Plan
Clinical Income Payment**

Prepared By: _____	Email: _____
Phone: _____	Date: _____

Clinical income is restricted to authorized clinical services by physicians in the School of Medicine. Justification to support the clinical income must be complete and the required approval must be obtained before this form will be processed for payment. Payment of clinical income is restricted to physicians for the payment of services that are not within the scope of the employee's normal working assignment. Use of the Clinical Income Payment form by any department should be infrequent. It must be used only in those unusual cases in which it is not appropriate to process the payment through the normal clinical income on-line process.

Employee's Name: _____

Department Name: _____

Org ID: _____

PLEASE SEE INSTRUCTIONS FOR COMPLETION OF THE CLINICAL INCOME PAYMENT FORM.

Employee ID #	Record #	Earnings Code	Additional Sequence	Amount
		CIP		

Pay Period Dates		Chartfield				
Start	End	Bu (2)	Org ID (5)	Activity/Project (8)	Account (5)	A/U (1)

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I certify that the requested payment for the above listed individual is in accordance with the department and University Clinical Income Plan Policy and procedures and any limitations set forth therein.

Department Authorized Signature

Date

Type or Print Name and Title

Telephone Number