THE University of Vermont MEDICAL CENTER

Office Use Only
OCTR Review Date:

Grant Closure Form

Study #: _____ **CHRMS #:** _____ **IRB Closure Date:** _____

Name of Study: _____

Principal Investigator: _____

Sponsor: _____

Please complete all fields unless not applicable is selected

Federal/State Funded	Yes ☐	No ☐	**If YES, contact GMF do not complete form**
All Per Patient Pymts Rec'd	Yes ☐	No ☐	**If No, do not complete this form**
All Misc. A/R Invoices Paid	Yes ☐	No ☐	**If No, do not complete this form**
All 960 Invoices Paid	Yes ☐	No ☐	**If No, do not complete this form**

Last Revenue Received

Date	Amount	Description

Last Expense Paid

Date	Amount	Description

	Check if Not Applicable		Date Paid	Comment
Detail of Invoiceables (if line itemed in contract)	☐	Monitor Fees		
	☐	Contract Change Fees		
	☐	Doc Storage		
	☐	Close out fees		
	☐	Annual IRB Admin Prep		
	☐	Pharmacy fees		
	☐	Advertising Fees		
	☐	Other		

Project Balance: _____

Please Note: If the residual balance is greater than 20% of the total amount provided by the sponsor(s) or $20,000, whichever is less, then it is considered to be a "significant balance". Additional documentation must be provided explaining how the work was completed without expenditure of the revenue received and confimation approval by the Chair/VP.

VP/Chair Signature (if required) _____ **Date:** _____

Request Transfer to New Sundry Fund ☐ Existing Sundry Fund ☐ Project Code: SU

If new, attach Sundry Fund Application Form

Charge to GL Account _____ Existing Fund ☐ Project Code: _____

Overspent balances may be charged to Sundry Funds or Operating accounts. They cannot be charged to active trials.

The signature of the PI below indicates that the above information is accurate. If any charges (patient care, salary & fringe, supplies, other) are posted subsequent to this transfer, the PI will be responsible for their payment from other funds.

Principal Investigator Signature: _____ **Date:** _____

Dept Assistant/Contact: _____ **Phone:** _____