Health Research Services (HRS)

ACCOUNT REQUEST FORM

Complete and email to hsresadm@mcmaster.ca or drop off in person at HSC-3H9

FOR OFFICE USE:

Date Received: *dd mmm yyyy*	***Proposal #:***	***Project #:***	***Date sent to Finance:*** *dd mmm yyyy*

*The Account Request (AR) Form is **companion** to an existing HRS Checklist. An AR Form **cannot** be used without an originating Checklist: it requires an originating Checklist with reference materials/paperwork for the original source of funds/funding.*

1a. ACCOUNT HOLDER INFORMATION

Account Holder Name:	MAC EMP ID:	Tel:
Department: Choose	Research Program, Centre, or Institute? Choose	
Acct Holder Role: Choose	Address:	Email:
McMaster co-applicants (list all):		

1b. SUPERVISOR INFORMATION (FOR TRAINEE ACCOUNTS)

Supervisor Name:	Department: Choose	Email:

2. ACCOUNT DETAILS *(see attached, additional forms where applicable)*

Account type: Choose	Attachment: Choose	Other form:

3. SOURCE FUNDS

Fund Source (Sponsor):	Original Source *(subgrants)*:
Account #/Chartfield:	Sponsor Ref #:

4. PROJECT INFORMATION

Project Title:

5. CONFLICT OF INTEREST

-- Do you, your co-investigators or any member of the research team have any affiliation, commercial or contractual interest, with or in any of the sponsor(s), suppliers or any company associated with the project? Y ◯ N ◉ If YES, who? Choose

If yes, what is nature of the potential conflict of interest? Choose

--Will funding for this project originate from an agency covered by the Financial Conflict of Interest regulations of the U.S. Public Health Service? http://www.fhs.mcmaster.ca/healthresearch/documents/USFCOIDisclosureForm.pdf) Y ◯ N ◉

6. BUDGET (attach detailed, current budget to match account request)

Funding Start Date: *dd mmm yyyy*	Funding End Date: *dd mmm yyyy*	Funding Currency: CAD OTHER-specify:
Total Funding Amt:	Does the project include indirect costs? Y ◯ N ◉ If yes, what percentage?	
Does the project include in-kind contributions? Y ◯ N ◉ If yes, how many separate sources?		
Is this a clinical trial? Y ◯ N ◉	If yes, cost/participant $ _____	Expected # participants _____

7. LOCATION OF PROJECT

MCMASTER UNIVERSITY		HAMILTON HEALTH SCIENCES		ST. JOSEPH'S HEALTHCARE	
Choose	%	Choose	%	Choose	%

8. ETHICS CERTIFICATIONS/CLEARANCES	N/A:	ASSURANCE #:	EXPIRY DATE: *dd mmm yyyy*
☐ Human participants, their records or tissues	☐		
☐ Animals and their tissues	☐		
☐ Biohazards (viruses, bacteria, cells, toxins, pathogens)	☐		
☐ Radioactive materials	☐		
☐ Controlled goods	☐		
☐ Health Canada clearance	☐		

***NOTE:** A copy of current assurances MUST accompany any account request.*

9. MEANING OF SIGNATURES

As grant and/or account holder and/or primary signing authority for this account (to be established in my name *if/when funds are received*), I confirm the declarations made previously herein and acknowledge and accept my responsibility:

1. to read, understand, and comply with all applicable sponsor policies, regulations, terms and conditions of award; and all University policies governing research projects, including, but not limited to, budget control, travel, ethics, and overhead;
2. to authorize all expenditures to be charged against my projects and/or delegate (see below) this authority at my discretion;
3. to inform persons delegated with signing authority on my research accounts of applicable sponsor and University requirements (as outlined in 1. above) and of their associated responsibility for compliance;
4. to obtain any additional approval signatures, which are required prior to making financial commitments;
5. to authorize and ensure delegate(s) authorize only allowable expenses against my research accounts, which may involve consultation with the applicable Research Finance Office and/or the sponsor;
6. to review monthly account statements to identify discrepancies and/or problems and to take corrective action in consultation with the applicable Research Finance Office;
7. to reimburse to the applicable research account(s) any expenditures authorized by me or my delegates if disallowed by the sponsor;
8. to eliminate any unauthorized over expenditures in accordance with the Budget Control Policy for Research Accounts, which, if all other alternatives have been exhausted, requires personal responsibility; and
9. to ensure all certifications are in order and comply with McMaster University and Federal regulations covering the ethical and safe conduct of research.

Department Chair/Institute Director certifies that:

- the proposed budget is consistent with the objectives of the PIs academic department;
- the campus resources to be committed to this project are accurately described in the proposal; and space will be provided for construction/renovations noted in the application (as above, further detail and sign-off required).

Account Holder:	**Department Chair:**
Signature:	Signature:
Name (print):	Name (print):
Date:	Date:
Supervisor (for trainee accounts):	**Institute Director/Dean (when applicable):**
Signature:	Signature:
Name (print):	Name (print):
Date:	Date:

ACCOUNT SIGNING AUTHORITY DELEGATION:

The originator (account holder or delegate) of electronic transactions is responsible for ensuring that the required supporting documentation is readily available for internal and external audit. In addition, I hereby grant the following people signing authority on my account. Any change in account signing authority will be authorized by me, in writing or by e-mail, and sent to the applicable Research Finance Office for action.

10. DELEGATES

Delegate Empl #:	Delegate Name:	Delegate Email:	Delegate Signature:

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