Reset Values

The University of Oklahoma Health Sciences Center

Stipend Enrollment

Name:_____ **Empl ID:**_____ **Monthly Stipend Amt:** _____

Grant Project Nbr:_____ **Start Date:**_____ **End Date:** _____

Fellowship or Training Grant PI: _____

Appointment Level: ☐ PreDoc ☐ PostDoc*

*Year _____

Chartfield(s):

Fund:_____ Org:_____ Program:_____ Subclass:_____ Project:_____ Split Amt:_____

Fund:_____ Org:_____ Program:_____ Subclass:_____ Project:_____ Split Amt:_____

Fund:_____ Org:_____ Program:_____ Subclass:_____ Project:_____ Split Amt:_____

I am requesting enrollment in the monthly grant stipend program. I understand I will receive payment on the 25th of each month. All information provided is true and accurate to the best of my knowledge.

_____ _____

Trainee/Fellow Signature Date

This stipend enrollment is approved for budget as outlined.

_____ _____

Budget Approver Signature Date

Please send complete Form to gca@ouhsc.edu.

For GCA Use Only: Date:_____ Initials:_____