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| --- | --- | --- | --- |
| **Name of Requestor** |  | | |
| **Name and Address of Company or Individual to whom the External Activities Will Be Provided** |  | | |
| **Description of Work** |  | | |
| **Estimated Number of Hours to Complete this Activity** |  |  |  |

By signing below, the Requestor confirms that, to the best of his/her knowledge and belief, all of the following are true:

* If the external activity is a research study, it was approved by a federally-accredited Institutional Review Board;
* The external activity will not be represented as being approved or endorsed by Harvard Pilgrim Health Care, Inc. (“HPHC”) or Harvard Pilgrim Health Care Institute, LLC (“HPHCI”) (collectively, “HPHC/I”) and will not be represented in publications or otherwise as emanating from HPHC/I;
* No data from HPHC/I information systems, HPHC/I staff, or other HPHC/HPHCI resources, including computers, will be used;
* The external activity will not induce clinical encounters, tests, or other forms of health care that would be delivered or paid for by HPHC;
* Data collection will not take place on HPHC/I premises;
* No HPHC/I employee serves as an investigator for the study, unless that employee is functioning in some capacity other than as an HPHC/I employee; and
* All external activity work will be conducted outside regular work hours and not on HPHC/I premises.

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| Certified by  **Requestor** |  |
| Acknowledged by  **Office of Sponsored Programs** |  |
| Approved by  **Chair, Dept. of Population Medicine** |  |
| Approved by  **Executive Director, HPHCI** |  |

If the Requestor wishes to deposit the payment from this consultancy into a General Purpose account, attach this signed form with a personal check made payable to “Harvard Pilgrim Health Care Institute.” The Requestor will receive a gift acknowledgement