HIGH POINT UNIVERSITY
Rx Fred Wilson School of Pharmacy

Standardized Client (SC) Payment Request Form

****Each SC is responsible for completing everything above the row of stars on his/ her hour sheet!****

First Name Middle Name Last Name

Complete Address
(Street/ PO Box, Apt # if applicable, City, State, and Zip Code)

Date	Start Time	End Time	Total Daily Hours	Case Number	Type of Hours (please only circle one per line)
			Round to nearest .25		
					Training Lab Admin
					Training Lab Admin
					Training Lab Admin
					Training Lab Admin
					Training Lab Admin
					Training Lab Admin
					Training Lab Admin
Total Hours for this sheet →					**The below signature certifies that I am registered to receive payment via Unimarket and that I am requesting payment for providing services as a standardized client as listed above.**
Hourly Rate →			$		
Total Payment Requested →			$		SC Signature: _____

****

The above named individual is approved to receive payment of $ _____ for providing the standardized client services listed on this form.

Signature - Director of Standardized Client Progam, Fred Wilson School of Pharmacy **Date of Approval**

Form updated 11/15/2018