

Residual Balance Certification form (Fixed Price)
except for Programs/Institutes and Centers

Award Number:		Award Start Date:
Sponsor Name:		Award End Date:
PI/Project Director:		Award Received Amount:
Award Type:		Expended Amount:
		Residual Balance:
Federal or Federal flow-through	Non-federal	

Prior to the transfer of a residual balance, F&A costs will be deducted from the accounts sum (at the rate assessed at award activation or 14.9%, whichever is greater). Additionally, for residual balances less than \$1,001.00 allocation will be as follows: PI retains 90%; Department Chair retains 5% and ORA retains 5% (in addition to the F&A). For balances greater than \$1,002.00 allocation will be as follows: PI retains 75%, Department Chair retains 10% and ORA retains 15%, in addition to the F&A).

Transfer To:	Allocation Amounts:	
Balance Award Number:	PI:	Department Chair:
Please create a new Balance Award	ORA:	

Justification of Residual Balance: For balances exceeding 10% of award amount or \$10,000.00, whichever is less. If more space is needed, please continue on separate page and attach).

Certifications:

PI: As the Principal Investigator responsible for the above-referenced award, I certify that: 1) all allocable expenses have been charged to the project and there are no further obligations; 2) all project activities were completed; 3) proposed level of effort or hours were fully expended, and 4) all deliverables and other programmatic requirements have been satisfied.

It is the PI's responsibility to **obtain all signatures below.**

Attach a copy of the IRB closeout form.

PI Name:	Signature/Date:
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Research Pharmacy: All pharmacy services have been invoiced and paid for. If N/A, check here and sign below.

Pharmacy representative:	Signature/Date:
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University Physicians of Brooklyn (UPB): All professional fees provided in service to this award have been invoiced and paid. If

N.A, check here and sign below:

UPB representative:	Signature/Date:
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Hospital Finance: The cost of all tests/procedures related to this study have been invoiced for and paid. If N/A, check here and sign below:

Hospital representative:	Signature/Date:
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OFFICE OF RESEARCH ADMINISTRATION USE ONLY
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Approved by: (Grant Manager)	Signature/Date:
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Approved by: (OM or designee)	Signature/Date:
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