SUNY RF
The Research Foundation for
The State University of New York

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

Award Number:

Sponsor Name:

PI/Project Director:

Award Type:

◯ Federal or Federal flow-through ◯ Non-federal

Award Start Date:

Award End Date:

Award Received Amount:

Expended Amount:

Residual Balance:

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% and ORA retains 10% (in addition to the F&A). For balances greater than $1,002.00 allocation will be as follows: PI retains 80% and ORA retains 20%, in addition to the F&A).

Transfer To:

◯ Balance Award Number:

◯ Please create a new Balance Award

Allocation Amounts:

PI:

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. PI is required to obtain signatures below.

PI Name: Signature/Date:

IRB: IRB confirms that the study is officially closed in IRBNet. If N/A, check here and sign below. ☐

IRBNet# IRB Study Title:

IRB Representative Name: Signature / Date:

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

Pharmacy representative Name: Signature/Date:

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 Name: Signature/Date:

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 Name: Signature/Date:

OFFICE OF RESEARCH ADMINISTRATION USE ONLY

Approved by: (Grant Manager) Signature/Date:

Approved by: (OM or designee) Signature/Date: