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

# Residual Balance Certification form (Fixed Price)

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%; 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:

Balance Award Number:

Please create a new Balance Award

Allocation Amounts:

PI:  Department Chair:

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: