Medicine

ANCILLARY PERSONNEL
AFFIDAVIT OF SALARY SOURCE

Name _____

Title _____

Department_____

Specialty_____

Sources of Salary:
(Please attach a copy of the FRF and complete below. If a portion of the salary is paid from a grant, please attach a copy of the grant.)

SOURCE (Account #)	**EFFECTIVE DATE** (Enter date)	**AMOUNT**	**GRANT NUMBER**
_____	_____	**$**_____	_____
_____	_____	**$**_____	_____
_____	_____	**$**_____	_____
	Total	**$**_____	

Percentage of time spent in patient care _____%.

Approvals:
The above individual functions in the capacity of ancillary personnel, and their salary is not reported on any hospital cost reports. In addition, the above individual does not receive any portion of base salary from a grant that provides reimbursement for patient care services. No change in the sources of salary will be made without written notification given to CU Medicine.

Department Chairman: Name _____

Signature_____

Date_____

Associate Dean – Finance and Administration – School of Medicine:

Signature_____

Date_____