



College of Pharmacy
Working Professional Doctor of Pharmacy Program

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MEMORANDUM

TO: Preceptors
FROM: Jackie Lavinder, Senior Secretary

SUBJECT: Payment for Services

Dear Preceptor:

Thank you for serving as a Preceptor for the College of Pharmacy Working Professional Pharm.D. Program, in order for us to pay you for your services, I am in need of some signed forms from you. **Make sure that the payee name you put on your Invoice/Verification form matches the payee name on your forms and submit requests by the deadline for submission dates listed on this form. Please mail them back to me at the address above, as I must have an original signature, not a fax.**

On the UF Consulting and Professional Worksheet, please review the directions on the form as most questions should be answered with a NO. If you answer yes to questions other than what is indicated in the directions, please contact me for further instructions. A new worksheet must be completed annually and payments cannot be processed without a current form. Payment will be mailed to the address on the worksheet or address correction should be indicated.

If you have indicated on your invoice that you want payment to go to a hospital or similar organization, please be sure to give us the FEID Number for that organization, not your personal SS# and contact me as additional forms need to be completed. Please bear in mind that any money earned does NOT generate a W-2 or 1099 at year-end.

Once you have completed the forms and mailed the originals to my address above (**DO NOT mail them to the addresses shown on the forms**) we can continue to process your invoice(s).

If you do not wish to receive payment, please sign this Letter below and fax or mail this Letter back to our office indicating that your services have been donated. This will allow us to refrain from bothering you with unnecessary paperwork. Please verify your address and phone number stated above by sending the completed Invoice/Verification form along with this Letter.

I do not wish to be paid for the services stated above.

NAME (Please print)

SIGNATURE

DATE