



ClinCard Participant Guidelines - Acceptance

By signing below I acknowledge, understand, and accept the following:

1. I acknowledge the receipt of the HJF Guidelines for ClinCard Prepaid Debit Cards and confirm that I have read and understood the procedures.
2. I am responsible for ClinCard prepaid debit cards distributed by Henry M. Jackson Foundation for the Advancement of Military Medicine, Inc. (HJF) in the requested amount of \$_____.
3. I understand that any unused cards not returned to the HJF Accounts Payable Department will be my personal responsibility as the custodian and I will be required to reimburse HJF.
4. I agree to use the ClinCard prepaid debit cards for HJF related purposes and agree not to use the funds for any personal use.
5. I understand that HJF may terminate the use of the ClinCard prepaid debit cards at any time. Termination of the use of the ClinCard prepaid debit cards may result from, but is not limited to: abuse, failure to follow the guidelines, use of funds for personal reasons, or lack of Project/Grant funds.
6. I understand that if my employment is terminated, I will notify HJF Accounts Payable of this action and provide the name of the person who will be taking over as custodian.
7. I understand that changes to the procedures may be made as circumstances make them necessary and any revisions will be deemed applicable, even if they are not signed for in this agreement.

HJF Prepaid Card Custodian Name _____
Print Name

Sign

Date

*Please attach the approved form during the time a requisition is entered by the program requisitioner.
(Please refer to the Guidelines and Procedures for ClinCard)
If any questions, please contact: ap@hjf.org or 240-694-4032.*