

UNIVERSITY OF KANSAS MEDICAL CENTER

Stipend Personnel Action Form  
Trainee-Fellowship

Student Name: \_\_\_\_\_ Address: \_\_\_\_\_  
SSN: \_\_\_\_\_ Address 2: \_\_\_\_\_  
Effective Date: \_\_\_\_\_ End/Termination Date: \_\_\_\_\_  
SpeedType: \_\_\_\_\_ Department No: \_\_\_\_\_  
Department Contact Name and Extension: \_\_\_\_\_

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**NEW APPOINTMENTS ONLY**

Rate: \_\_\_\_\_ Monthly Payment: \_\_\_\_\_ One-Time Payment: \_\_\_\_\_  
Stipend Pick-up/Mail: \_\_\_\_\_ US Citizen Yes or No \_\_\_\_\_ Visa Type \_\_\_\_\_  
Job Description (check one): \_\_\_\_\_ Undergraduate Seeking Student  
\_\_\_\_\_ Master's Degree Seeking Student \_\_\_\_\_ PhD/MD Seeking Student  
\_\_\_\_\_ Post Doctoral Seeking Student \_\_\_\_\_ Other (Please Specify) \_\_\_\_\_

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**BUDGETING APPROVAL STATUS**

Research Institute: \_\_\_\_\_ Date: \_\_\_\_\_  
Budget: \_\_\_\_\_ Date: \_\_\_\_\_  
Student Financial Aid: \_\_\_\_\_ Date: \_\_\_\_\_

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**CHANGE STATUS**

Stipend Rate Change: From \$ \_\_\_\_\_ To \$ \_\_\_\_\_  
Name Change: From \_\_\_\_\_ To \_\_\_\_\_  
SpeedType Change: From \_\_\_\_\_ To \_\_\_\_\_

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**DEPARTMENTAL APPROVAL**

Department Signature: \_\_\_\_\_ Date: \_\_\_\_\_