

**CONSENT AND STATEMENT PURSUANT
TO TREAS. REG. § 31.6402(a)-2(a)(2)**

For the purpose of enabling the Medical University of South Carolina (“University”) to file claims for refund of the employee share of FICA tax withheld from stipend payments to me as a Medical Resident or Fellow by the University during the calendar quarterly periods from _____ through _____, I hereby consent to the filing of such claims and the allowance of the claimed refunds and state that (a) I have not claimed a refund or credit of the employee tax for these periods and (b) I will not claim a refund or credit of the employee tax for these periods. I understand that the University will promptly remit to me the amount of any FICA tax withheld from my stipend which is subsequently refunded to the University pursuant to the University’s claims for refund.

(Date)

(Signature)

You are responsible for notifying MUSC of any change to the address you list below, as this is the address to which MUSC will mail your portion of the refund if the refund claim is successful. Notification must be mailed or faxed to the MUSC location below.

PLEASE PRINT OR TYPE:

Name

Address

City, State, Zip

E-mail address: _____

Employee ID number: _____

Return to:
Medical University of South Carolina
Attn: Resident FICA Claims
19 Hagood Avenue, Suite 505
MSC 817
Charleston, SC 29425-8170

Consent form may be faxed.
Fax number: 843-792-5185

Questions: 843-792-0505

Deadline: To be determined

Date Received: _____