

RESEARCH GRANT INVOICE

[Institution/Organization Name]

[Department/Unit]

[Street Address, City, State, Zip]

INVOICE NUMBER
[000000]

DATE
[MM/DD/YYYY]

BILL TO (SPONSOR)

[Sponsor Name / Pharma Co.]

[Contact Person]

[Billing Address]

TRIAL INFORMATION

Protocol ID: [Protocol Number]

IRB Number: [IRB Number]

PI Name: [Principal Investigator]

Description of Service / Milestone	Subject ID (if applicable)	Quantity	Unit Cost	Total
[e.g., Patient Enrollment / Visit 1]	[ID-001]	[1]	[\$0.00]	[\$0.00]
[e.g., Pharmacy Setup Fee]	-	[1]	[\$0.00]	[\$0.00]
[e.g., Case Report Form Completion]	[ID-001]	[1]	[\$0.00]	[\$0.00]
			Subtotal	[\$0.00]

Description of Service / Milestone	Subject ID (if applicable)	Quantity	Unit Cost	Total
Indirect Costs ([%] Overhead)				[\$0.00]
Grand Total Due				[\$0.00]

PAYMENT INSTRUCTIONS

Bank Name: [Bank Name]

Account Name: [Account Name]

Account/IBAN: [Number]

SWIFT/BIC: [Code]

Certification: I certify that the above services have been performed in accordance with the clinical trial agreement.

AUTHORIZED SIGNATURE