

# RESEARCH GRANT INVOICE

Invoice #: \_\_\_\_\_

Date: \_\_\_\_\_

**Institution/Organization Name**

Department of Public Health

Address Line 1

City, State, Zip

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**BILL TO:**

Granting Agency Name

Attn: Grants Management Office

Address Line 1

City, State, Zip

**PROJECT DETAILS:**

Grant Award #: \_\_\_\_\_

Project Title: \_\_\_\_\_

Principal Investigator: \_\_\_\_\_

Performance Period: \_\_\_\_\_

Budget Category / Description	Cumulative Prior	Current Period	Total to Date
Personnel (Salaries & Fringe)	\$	\$	\$
Research Supplies & Lab Consumables	\$	\$	\$
Participant Incentives / Recruitment	\$	\$	\$
Travel & Field Work	\$	\$	\$

Budget Category / Description	Cumulative Prior	Current Period	Total to Date
Indirect Costs (___%)	\$	\$	\$

Current Amount Due: \$ \_\_\_\_\_

Remaining Grant Balance: \$ \_\_\_\_\_

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**CERTIFICATION:**

I certify that the above expenditures are true and correct, and that all disbursements were made in accordance with the terms and conditions of the grant agreement.

Authorized Signature: \_\_\_\_\_ Date: \_\_\_\_\_