INVOICE

[Research Institution Name]
[Department of Clinical Compliance]
[Street Address]
[City, State, Zip Code]

INVOICE NUMBER [INV-000]
DATE [MM/DD/YYYY]

BILL TO:

[Sponsor or CRO Name]
[Contact Person]
[Address Line 1]
[Address Line 2]

STUDY REFERENCE:

Protocol ID: [Protocol Number]
IRB Number: [IRB Number]
PI Name: [Principal Investigator]

Service Description	Units/Hours	Rate	Amount
IRB Regulatory Submission & Compliance Review	[0]	$[0.00]	$[0.00]
Clinical Quality Assurance Audit (Site Visit)	[0]	$[0.00]	$[0.00]
FDA/GCP Compliance Monitoring Fee	[0]	$[0.00]	$[0.00]
Regulatory Binder Management & Archiving	[0]	$[0.00]	$[0.00]

Subtotal: $[0.00]

Tax / Administrative Overhead: $[0.00]

Total Due: $[0.00]

PAYMENT INSTRUCTIONS

Please make checks payable to **[Institution Name]**.
Wire Transfer: [Bank Name] | SWIFT: [Code] | Account: [Number]
Payment Terms: Net 30 Days