NORTH
MEMORIAL HEALTH

CLINICAL RESEARCH SPONSOR INVOICE

NORTH MEMORIAL HEALTH
[Department Name]
[Address]
[City, State, ZIP]
[Phone Number]
[Email Address]
[Tax ID Number (if applicable)]

INVOICE
Invoice #: [Number]
Date: [MM/DD/YYYY]
Due Date: [MM/DD/YYYY]

BILL TO:
Sponsor Company Name
[Contact Person Name]
[Company Address]
[City, State, ZIP]

STUDY INFORMATION
Study Title: [Full Protocol Title]
Protocol Number: [Protocol #]
Site Number: [Site ID]
Principal Investigator: [Name]
IRB Number: [if applicable]

Invoice Summary (EXAMPLE)

Description of Services	Visit/Activity Date(s)	Quantity	Unit Cost	Total
Screening Visit	[Date(s)]	[Qty]	[$ Amount]	[$ Amount]
Baseline Visit	[Date(s)]	[Qty]	[$ Amount]	[$ Amount]
Follow-up Visit	[Date(s)]	[Qty]	[$ Amount]	[$ Amount]
Lab Sample Processing Fees	[Date(s)]	[Qty]	[$ Amount]	[$ Amount]
Pharmacy Dispensation Fees	[Date(s)]	[Qty]	[$ Amount]	[$ Amount]
Regulatory Start-up Fee	[One-time]	1	[$ Amount]	[$ Amount]

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Description of Services	Visit/Activity Date(s)	Quantity	Unit Cost	Total
IRB Submission/Continuing Review	[Date]	1	[$ Amount]	[$ Amount]
Other (specify)	[Date(s)]	[Qty]	[$ Amount]	[$ Amount]

Total Amount Due: $[Total]

Payment Instructions
Please make payment to:
Payee Name: [Your Legal Entity Name]
Bank Name: [Bank Name]
Routing Number: [Routing #]
Account Number: [Acct #]
Payment Reference: Invoice #[Invoice Number] / Protocol #[Protocol Number]

Notes:

- *Payment due within [Net 30/45/60] days from the invoice date unless otherwise specified in the CTA.*
- *Please direct any inquiries to: [Your Contact Info]*
- *Attach relevant source documentation (e.g., visit logs, signed CRFs) as per sponsor requirements.*

_____
Printed Name

_____
Signature Date