|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Study Information | | | | |
| Study Reference Number: | |  | | |
| Study Ethics Approval Number: | |  | | |
| Study Name: | |  | | |
| Principal Investigator: | |  | | |
| Study Contact: | |  | | Phone: |
| Departmental Approval for Research | | | | |
| Department/Area | | Operational Impact? | Compensation Required? | Can Department Provide Services for the Research Project? |
|  | | Choose an item. | Choose an item. | Choose an item. |
| Please provide a summary of services required for the research study: | | | | |
| Quotation for Cost Recovery | | | | |
| Service | | | | Cost per Unit |
|  | | | |  |
|  | | | |  |
|  | | | |  |
|  | | | |  |
|  | | | |  |
| Total Fees Payable to AHS Department | | | |  |
| “Unit” could refer to tests, patients enrolled, charts pulled, staff time, etc. | | | | |
| Details for Invoicing and Payment | | | | |
| Payer Details | Institution:  Department:  Research Account Number:  Speed Code (if applicable): | | | |
| Recipient:  AHS Account Details | Balancing Unit (3 digits):  Location (4 digits):  Functional Centre (11 digits): | | | |
| Please indicate any conditions and/or timeline obligations for invoicing and payment: | | | | |
| Authorization | | | | |
| Name of AHS Department Approver | | | Sign  x | |
| Title of AHS Department Approver | | | Date: | |
| Signature of Principal Investigator | | | Sign  x | |
|  | | | Date: | |