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| --- |
| 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      | Signx |
| Title of AHS Department Approver      | Date:       |
| Signature of Principal Investigator       | Signx |
|  | Date:       |