LOYOLA UNIVERSITY HEALTH SYSTEM

Invoice [LU]-MM-YYYY
Invoice Date:
Payment Due:

Principal Investigator	
LU#	
Sponsor Type	

Service Date	Description	Quantity	Charge
		Total:	

Budget Administrator: _____ **Date:** _____

Name:_____ Phone:_____

Secondary Approver: _____ **Date:** _____
Secondary Approval REQUIRED on all requests in excess of $5,000

By signing this invoice, I certify that these charges are consistent with the information provided by the department and reflect allowable study charges per enrolled subject. The study has available funding to cover these costs or an alternate funding source is provided in the comments section.

Comments:

Remit To: Loyola University Medical Center
Attn: Ivonne Arroyo
Building 101 Room 1752
2160 South First Avenue
Maywood, IL 60153