Clinical Trial Billing Notification Form

Date

Payment Schedule per contract:
- ◯ Milestones
- ◯ Per Patient
- ◯ Start up
- ◯ Other

Principal Investigator

Sponsored Program Number

Study Sponsor

Protocol Number

DESCRIPTION	AMOUNT

Total Direct Cost 0

F&A % F&A Cost 0

Grand Total 0

CONTACT PERSON

name

phone number

email address

ADDITIONAL COMMENTS

Please complete this form accurately and in its entirety to assist in ensuring precise, complete, and timely billing and collections. Please save form as PDF file and email to Kristin Sacca at ksacca@bu.edu. If you have any questions or need assistance in completing this form, please contact Kristin at 617-358-5117.

RESET FORM

PRINT FORM