

SPONSOR NAME

SPONSOR ADDRESS

SPONSOR EMAIL

Invoice no. : REB# XX-XXX

Invoice date : DATE

Invoice

SMH Investigator: PI NAME

|  |  |
| --- | --- |
| REB APPLICATION FEE | Amount |
| STUDY TITLE  PROTOCOL # | $3,000.00 |
| Processing fee is not included in the total amount. Total CAD | $3000.00 |

**Amount Due: $3000.00 CAD**

Please made cheque payable to: UNITY HEALTH TORONTO

Research Administration

30 Bond Street

Toronto, Ontario

M5B 1W8

Attn: RESEARCH FINANCE

***\* Please refer to invoice number when making payment***

Contact Information: COORDINATOR NAME

POSITION

Tel: 416-864-6060 x xxxx

Fax: 416-864-6043

E-mail: