

SPONSOR NAME

SPONSOR ADDRESS

SPONSOR EMAIL

Invoice no. : REB# XX-XXX

 Invoice date : DATE

Invoice

SMH Investigator: PI NAME

|  |  |
| --- | --- |
| REB APPLICATION FEE  | Amount |
| STUDY TITLEPROTOCOL #  | $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

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 E-mail: