Florida Public Health Research Programs
INVOICE

Invoice #: _____

DOH Grant #: _____

Institution's Official Name and Address (listed on W-9):

Institution Name:

Street Address:

City, State, Zip: ,

Remit to Name and Address ("same as above" if same as Official Address):

Institution Name:

Street Address:

City, State, Zip:

Federal ID#:

Financial Contact Name:

Financial Contact Phone:

DELIVERABLES	Period Covered	Invoice Amount
☐ Invoice ○ Quarterly ○ Final ☐ Financial Report ○ Quarterly ○ Final ☐ Expenditure Report ○ Quarterly ○ Final ☐ Progress Report ○ Quarterly ○ Final ☐ Proof of Liability Insurance (see Attachment II for Due Date) ☐ Florida Legislature Progress Report ○ Annual ○ Final *This grant provides research data with the goal of prevention, diagnosis, and treatments, to expand the foundation of biomedical knowledge and improve the health of Floridians.*		

CERTIFICATION:

By providing this electronic signature, I am attesting that I understand that electronic signatures are legally binding and have the same meaning as handwritten signatures. I am also confirming that internal controls have been maintained, and that policies and procedures were properly followed to ensure the authenticity of the electronic signature. This statement is to certify that I confirm that this electronic signature is to be the legally binding equivalent of my handwritten signature and that the data on this form is accurate to the best of my knowledge.

_____ _____

Authorized Signature **Date**

1. **PLEASE SUBMIT ALL DELIVERABLES BY UPLOADING TO *PEERNET*.**
2. **INVOICES WILL NOT BE PROCESSED FOR PAYMENT UNTIL ALL DELIVERABLES ARE RECEIVED AND APPROVED**
3. ***ALL* DELIVERABLES MUST BE RECEIVED PRIOR TO THE DUE DATE LISTED IN THE ATTACHMENT II, OR A FINANCIAL CONSEQUENCE WILL BE REDUCED FROM THE INVOICE (SECTION 5, TERMS & CONDITIONS)**

**** FOR DEPARTMENT OF HEALTH USE ONLY ****

Date Invoice Received: _____

TOTAL AMOUNT AUTHORIZED: _____

Date Revisions Received: _____

Date Invoice Approved: _____
(Complete Deliverables Packet Approved) *(same date as Grant Manager's signature below)*

SIGNATURE OF SUPERVISOR:

_____ _____
Deputy Director, Biomedical Research Section *Date*
Public Health Research

SIGNATURE OF GRANT MANAGER:

_____ _____
Grant Manager/Liaison, Biomedical Research Section *Date*
Public Health Research

☑ CERTIFICATION:
By providing this electronic signature, I am attesting that I understand that electronic signatures are legally binding and have the same meaning as handwritten signatures. I am also confirming that internal controls have been maintained, and that policies and procedures were properly followed to ensure the authenticity of the electronic signature. This statement is to certify that I confirm that this electronic signature is to be the legally binding equivalent of my handwritten signature and that the data on this form is accurate to the best of my knowledge.

All Deliverables approved on this invoice are referenced on the Invoice Performance Analysis form and inclusive of the requirements of the Grant Terms & Conditions, Attachment II Payment Schedule (attached).