



Florida Public Health Research Programs INVOICE

Date Invoice
Received:

DOH Grant #: _____ Invoice #: _____

Date
Revisions
Received:

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)

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

Institution Name:

Street Address:

City, State, Zip:

Date Invoice
Approved:
(Complete Deliverables
Packet Approved)

Remit to Name and Address (Must match remittance address in My Florida Market Place and Federal ID# plus sequence number associated with the Remittance address)

Institution Name:

Street Address:

City, State, Zip:

Federal ID#:

Include 3 digit Sequence Number

Financial Contact Name:

Financial Contact Phone:

DELIVERABLES (Mark All That Apply - Must Match Terms & Conditions Attachment II)					FOR DOH USE ONLY
Invoice	Quarterly	Final	Period Covered	Invoice Amount	Financial Consequences Applied:
Financial Report	Quarterly	Final			
Expenditure Report	Quarterly	Final			Revised Invoice Amount:
Progress Report	Quarterly	Final			
Proof of Liability Insurance (see Attachment II for Due Date)					
Florida Legislature Progress Report	Annual	Final			
<i>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.</i>					

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 signatures. 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

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

<p>SIGNATURE OF GRANT MANAGER/LIAISON:</p> <p>_____ Grant Manager/Liaison, Biomedical Research Section Public Health Research</p> <p>By providing this electronic signature, I, _____</p> <p>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 signatures. 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.</p>	<p>SIGNATURE OF SUPERVISOR:</p> <p>_____ Deputy Director, Public Health Research</p> <p>By providing this electronic signature, I, _____</p> <p>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 signatures. 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.</p>
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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).