

THE OHIO STATE UNIVERSITY RESEARCH FOUNDATION
1960 Kenny Road, Columbus Ohio 43210-1063

CONSULTANT INVOICE

Invoice Date:

Invoice No.:

RF Project No.:

RF Purchase Order No.:

Consultant Information:

Name:

Home Address:

Phone No.:

Email Address:

Billed To: The Ohio State University Research Foundation, Accounts Payable

U.S. Citizen:

Resident Alien or Permanent Resident:

Non-Resident Alien:

Location of Services: In U.S.: Outside U.S.:

Brief Description of Consulting Services Performed:

Date(s) of Services Rendered: From:

To:

Choose the Appropriate Fee for Services *(must agree with the Consultant Agreement):*

Daily Rate: \$ X No. of Days: = Total Amount Requested: \$

Hourly Rate \$ X No. of Hours: = Total Amount Requested: \$

Other (provide amount and basis for fee reimbursement): \$

I certify that I have performed the services described above:

Consultant Signature

Date

Approved for Payment:

Principal Investigator Signature

Typed Name

Date