**SESLHD RESEARCH**

**METHOD OF PAYMENT FORM**



Please note that your submission will be progressed upon confirmation of payment

|  |  |
| --- | --- |
| 1. **ADMINISTRATIVE INFORMATION** | |
| * 1. **STUDY DETAILS** |  |
| **STUDY TITLE** |  |
| **REFERENCE NUMBER** | e.g. FOR ETHICS – YEAR/ETHXXXXX OR FOR GOVERNANCE – YEAR/STEXXXXX |
| **REGIS AMENDMENT NUMBER** | IF APPLICABLE |
| **AMENDMENT DETAILS** | For amendment applications, please provide a description of the amendment here (i.e protocol amendment 5). Please note this will accompany the invoice to the Sponsor so please ensure it is clear to avoid processing delay. |
| **PROTOCOL NUMBER** |  |
| **SITE #** | FOR COMMERCIAL STUDIES |
| **SUBMISSION DATE** |  |
| **FUNDING SOURCE NAME** | e.g. MRFF, NHMRC, Trust Fund or Recurrent Funding of CC XXX XXX |
| **SPONSOR** |  |
| **1.2 PRINCIPAL INVESTIGATOR** |  |
| **NAME** |  |
| **EMAIL ADDRESS** |  |
| **CONTACT NUMBER** |  |
| **ORGANISATION** | Unit, Department, Organisation |
| **1.3 PERSON COMPLETING FORM** | NOT APPLICABLE: AS ABOVE |
| **NAME** |  |
| **EMAIL ADDRESS** |  |
| **CONTACT NUMBER** |  |
| **RELATIONSHIP TO PROJECT** |  |

***If the payment is mixed, please complete both sections stating the amount for each***

|  |  |  |
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| 1. **BILLING/INVOICE INFORMATION** | | |
| *2.1* **PAYMENT TYPE** | **INTERNAL COST TRANSFER  EXTERNAL FUNDING SOURCE** | |
| *2.2* **INTERNAL COST TRANSFER** | FUNDS WILL BE TRANSFERRED FROM COST CENTRE BELOW TO SESLHD RESEARCH OFFICE | |
| **COST CENTRE NAME** |  | |
| **COST CENTRE NUMBER** |  | |
| **COST CENTRE MANAGER SIGNOFF** |  | |
| *2.3* **EXTERNAL FUNDING SOURCE** | INVOICES WILL BE DIRECTED TO THE NOMINATED PARTY BELOW | |
| **DEBTOR NAME** |  | |
| **ABN** |  | |
| **BILLING ADDRESS** |  | |
| **CONTACT NAME** |  | |
| **CONTACT NUMBER** |  | |
| **CONTACT EMAIL** |  | |
| 1. **Declaration** | |  |
| **PI or Delegate declares that have read and understood the** [**NSW Health Fee Policy**](https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2025_017) **and [Information Bulletin](https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=IB2025_014) [[1]](#footnote-1)** **YES**  **PI or Delegate declares that the above-mentioned information is complete and correct**  **YES**  **PI or Delegate declares that the correct Research Fees are being included in the study budget YES** | | |

**Name and Title Signature Date**

1. Reference Policy URL:

   Policy Directive: [Fee Schedule for Research Ethics and Governance Review of Clinical Trial Research (nsw.gov.au)](https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=PD2025_017)

   Fee Schedule Information Bulletin: [Fees for Research Ethics and Governance Review of Clinical Trial Research (nsw.gov.au)](https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=IB2025_014) [↑](#footnote-ref-1)