



Date	Requested By	Date Required By	Telephone	GLAVREF Fund #

Payment for Services
(Invoice Attached with SS#/Tax ID)

Reimbursement
(Original Receipts Attached)

Patient Study Payment
(Patient SS#/ and Address)

Payment of Invoice or Order Placement
(Attach original invoice or order form)

VA Project Number

Description/Research Justification	Amount
Total Payment Amount:	

Payee Name:

Mailing Address:

Social Security Number:

(Required for Patient and Consultant Payments)

Special Payment Instructions:

Mail Directly

Hold for Pick Up

GLAVREF Authorized Signature
(required)

Contact Name:

Telephone:

Picked Up By:

Requestor Authorized Signature
(required)