# *Invoice SafeBoosC Trial:*

**Name of Contact:** Gorm Greisen.

Invoice date

**PSP:** F-22075-04

**Organization:** Rigshospitalet, Dept of Neonatology 5024

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**Adress:** Blegdamsvej 9,

**ZIP code:** 2100 Copenhagen Ø

**Country:** Denmark

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Please specify the service delivered in terms of Cost (according to the budget).

Please choose:

**Salaries:**

☐ Salaries of scientific staff _____DKK

☐ Salaries of technical/administrative(and clinical) staff _____DKK

**Operational Expenses:**

☐ Equipment _____DKK

☐ Travel _ _____DKK

☐ Other expenses _____DKK

Total amount requested:____ _____DKK

| | |
|---|---|
| Company Name : | |
| Adress : | |
| Adress : | |
| Your ref. : | |
| Postal code : | |
| City : | |
| Country : | |
| E-mail (compulsory) : | |
| VAT number (intercom): | |

BANK ACCOUNT NUMBER : Please attach a bank identification number

| | |
|---|---|
| Name of bank : | |
| city : | |
| Country : | |

| | |
|---|---|
| Bic code (or Swift code) : | |
| Routing Number (or ABA, branch transit) : | |
| Account number : | |
| IBAN : | |

I hereby declare that the costs have been used according to the intention of the funding from DSRC:

Date and Signature: _____