

**School of Medicine  
Check Transmittal Form**

**PI:** \_\_\_\_\_ **Department:** \_\_\_\_\_

**Sponsor:** \_\_\_\_\_ **Payor:** \_\_\_\_\_  
(if different from sponsor)

**Title of Project:** \_\_\_\_\_

**Protocol Number:** \_\_\_\_\_  
(required)

**Check Number:** \_\_\_\_\_ **Check Date:** \_\_\_\_\_  
(mm/dd/yyyy)

**Amount of Check:** \$ \_\_\_\_\_

**New Account needed?:** (if yes check here)

**Project #**

**Award #**

**Org #**

\_\_\_\_\_  
**Principal Investigator Signature**  
**Date:** \_\_\_\_\_  
(mm/dd/yyyy)

\_\_\_\_\_  
**Research Administrator Signature**  
**Date:** \_\_\_\_\_  
(mm/dd/yyyy)

\_\_\_\_\_  
**Grants and Contracts Reviewer Signature**  
**Date:** \_\_\_\_\_  
(mm/dd/yyyy)

