Payment Request for Helsinki Fees

Date: _____

Company name: _____

Name of Company contact: _____ Telephone number: _____

Helsinki Number: _____ Protocol Number: _____

PI Name: _____ Department: _____

Payment for:

- ☐ New submission (including applications submitted to the Central Committee) – **4,000** NIS
- ☐ New Genetic Sub study submission – **2,000** NIS
- ☐ Continuation protocol – **800** NIS
- ☐ Request for changes:
  - ☐ Inform Consent form – **800** NIS ☐ Protocol – **800** NIS ☐ IB – **800** NIS

Payment Reference: _____

Bank Information:

Bank Name: **HAPOALIM**
Account Name: **SOROKA UNIVERSITY MEDICAL CENTER**
Bank Address: **98 YIGAL ALON ST. TEL AVIV, ISRAEL**
IBAN: **IL-620120630000000211122**
SWIFT(OR BANK) CODE: **POALILIT**
ACCOUNT NO. **12-063-211122**

Please submit payment reference along with this form to the Helsinki Committee

Sincerely,

SOROKA UNIVERSITY MEDICAL CENTER
YAFFA ASHUR, MD
Deputy Director General

Yaffa Ashur, MD, MHA
Deputy Director General
Soroka University Medical Center