SOROKA Medical Center feeling secure | CLALIT HEALTH

Date: ________________

Payment Request for Helsinki Fees

Company name :____

Name of Company contact: ____________________ Telephone number: ________________

Helsinki Number: _______________ Protocol Number: ______________________________

PI Name: ___________________________ Department: ______________________________

Payment for:

- ☐ New submission – **7,500 NIS**
- ☐ Changes / adding information to documents after initial submission – **1,000 NIS**
- ☐ Significant changes (in documents or product) required for approval– **1,000 NIS**

Payment Reference:______________________

Bank Information:

Bank Name: **HAPOALIM**
Account Name: **SOROKA UNIVERSITY MEDICAL CENTER**
Bank Address: **26 HAROKMIM. HOLON, ZIP CODE 5885849 ISRAEL**
IBAN: **IL-620120630000000211122**
SWIFT (OR BANK) CODE: **POALILIT**
ACCOUNT NO. **12-063-211122**
Company Registration Number**: 589906114**

Please submit payment reference along with this form to the Research Coordinator

Sincerely,

Prof. Roy Kessous , MD
Deputy Director General
Soroka University Medical Center

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