Date Form Submitted: _____

Single Cell Core Billing Form

*USER NAME: _____

*EMAIL ADDRESS: _____

*LAB NAME: _____

*LAB AFFILIATION: _____

HARVARD MEDICAL SCHOOL INVESTIGATORS (with 33-digit codes)

Financial Contact Information (the grants manager for your laboratory):

NAME: _____

EMAIL: _____

TELEPHONE: _____

*SIGNATURE (of grants manager):_____ *Date: _____

33-DIGIT ACCOUNT NUMBER: _____

*Expiration Date: _____

Note: The Finance Office will confirm the 33-digit account number with the financial contact, and provide a statement of the charges incurred.

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NON-HARVARD MEDICAL SCHOOL INVESTIGATORS

Make POs payable to Harvard University-Accounts Payable; PO BOX 4999; Boston, MA 02212-4999

PO NUMBER for single use (one-time fee):_____

*PO Amount: $_____ *PO Expiration Date: _____

PO NUMBER for repeated use (open; may be charged to more than once):_____

*PO Amount: $_____ *PO Expiration Date: _____

NAME and ADDRESS WHERE INVOICE SHOULD BE SENT:
(Please include a contact name and phone number or email address)

*Required Field

Contact: Sarah Boswell@hms.harvard.edu •

Shipping Address: HMS Single Cell Core • 200 Longwood Avenue • Armenise 561 • Boston, MA 02115
Billing Address: Harvard University • P.O. Box 4999 • Boston, MA 02212