Purchase Order for Professional Services (formerly PSOs)
INVOICE

INVOICE # [*last name+date*]
DATE: ___/___/___
Three Way Match
*** No other invoices will be submitted for this service***

NAME_____
ADDRESS _____
_____
DUNS number _____ *****
*/ DUNS number or DUNS+4, as registered in CCR
Vendor or Tax ID (when available) _____

TO:
NIH OFM
Commercial Accounts
2115 East Jefferson Street
Room 4B-432, MSC 8500
Bethesda, MD 20892-8500

FOR:
Contract #: HHSN_____
TODO/PO/BPA Call#: _____
GSA Contract #: _____
Other Reference: _____

DESCRIPTION	QTY	RATE	AMOUNT
Honorarium	1	$	$
Per Diem	1	$	$
Transportation	1	$	$
		Total	**$**

Payment is requested in the amount of **$**_____.

_____ _____
Signature Date

_____ _____
Remittance Contact Name/Title Phone

_____
E-Mail Address

Receiving Report
OFM - Information Only
To Be Completed by IC Receiving Official
Name_____
Title_____
Bldg/Room/Phone_____
Signature_____
Date Item(s) Received_____