Boston University
Medical Campus

School of Medicine
School of Dental Medicine
School of Public Health

Date:
Team:
Unit / Dept:
Source:

Authorized Signature Form

TO: BU Office of Research Accounting, 25 Buick St., 2nd floor, fax 617-353-6740

FROM: (insert principal investigator name)

The personnel listed below, for this account only, are authorized to sign the following designated type(s) of accounting documents, and their signatures may be accepted as of the date indicated above. All initial faculty appointments and changes in faculty salary rates will be approved by the Principal Investigator and the Department Chairperson. The Dean of the School will approve changes in salary rates for Department Chairpersons.

Type of Document

A. All Payroll Documents
B. Requisitions/Work Orders
C. Invoice Transmittal
D. Check Request Voucher
E. Travel Expense Reports
F. Petty Cash
G. Travel Advance Voucher
H. Receipt Acknowledgement
Z. All Documents (A-H)

Please print in black ink or type all information requested, except the signature specimen

UIS User ID	BU ID Number	NAME Last Name, First	SIGNATURE Specimen	Type(s) of Document(s)

Any Special Instructions: _____

This form supersedes all prior forms covering this account

Signed: _____

Dean, Department Chairperson, or Principal Investigator