Attachment A:
Hospital Invoice

Georgia Hospital Association
380 Interstate North Parkway SE, Suite 150
Atlanta, Georgia 30339
Phone: 770-249-4500 Fax: 770-955-5801

Authorization to Pay: _____

Date: _____

Hospital Name: _____

Please Specify Hospital's Preferred Method of Payment (*Please Only Check One Box*):

☐ **Check**
- ***Please Remit Checks To (Physical Address):*** _____
  _____
  _____
- ***Make Check Payable To:*** _____
- ***Send to the Attention Of:*** _____

☐ **Electronic Funds Transfer**
- ***Name on Bank Account:*** _____
- ***Adddress:*** _____
- ***Federal Tax ID Number:*** _____
- ***E*-mail Address for Remittance Details:** _____
- ***Bank Name:*** _____
- ***Bank Address:*** _____
  _____
- ***Beneficiary Name*:** _____
- ***Account Number*:** _____
- ***Routing Number*:** _____

Total Invoice Amount: $ 5,000

Our hospital agrees to accept the Funds as a result of selecting an intern and performing the responsibilities described in the MOU.

Signature:_____

Name: _____ ***Title:*** _____ ***Date:*** _____

Email:_____ ***Phone:***_____