

**NEW YORK UNIVERSITY MEDICAL CENTER  
REQUEST FOR COST TRANSFER**

Kindly adjust your records for the following cost transfers as fully explained and certified below.

**A. Cost Transfer**

ITEM	ORIGINAL CHARGE		FROM	TO
	Date MM/YY	Amount	Fund- Org- Prog- Proj- Account Note: Leave program blank	Fund- Org- Prog- Proj- Account Note: Leave program blank
<b>Personnel:</b> Last Name, First Name #Employee ID-Emp Rec- BI/MO				
SMITH, JOHN #100123 – 1 – MO	05/06	10,000.00	15-B0001- -12345-53200	26-B0001- -54321-53200
<b>OTPS:</b> Description of Expense				
Lab Supplies	05/06	5,000.00	26-C0001-12345-12345-67085	26-C0001-12345-12345-67085

**B. Explanation and Justification for Transfer**

**C. I certify that the above requested transfer is appropriate and will not result in a deficit.**

_____	_____	_____	_____
Principal Investigator	Date	Sponsored Programs Financial Services	Date
_____	_____	_____	_____
Financial Analyst	Date	Senior Director/Vice Dean	Date

Cost Transfer Prepared By: \_\_\_\_\_