



MEDICAL UNIVERSITY OF SOUTH CAROLINA
SPEAKER FEES/LECTURE FEES CONFIRMATION
FOR USE WHEN TOTAL PAYMENT < \$1,500

TO: _____

FROM: _____

This letter will confirm our invitation to you for your engagement at the Medical University of South Carolina for your presentation on: _____
DATE

BREAKDOWN OF PAYMENT (TOTAL NOT TO EXCEED \$1,500)
TOTAL TRAVEL/OUT OF POCKET _____
TOTAL FEE: _____

--NAME, ADDRESS, SOCIAL SECURITY NUMBER AND RECIPIENT SIGNATURE:

NAME: _____

ADDRESS: _____

SOCIAL SECURITY NUMBER: _____

SIGNATURE: _____

PLEASE RETURN THIS FORM TO _____
NAME OF DEPARTMENT

AT THE FOLLOWING ADDRESS:
ATTENTION: _____
(NAME OF DEPARTMENT)

MEDICAL UNIVERSITY OF SOUTH CAROLINA
171 ASHLEY AVENUE
CHARLESTON, SOUTH CAROLINA 29425

<p><u>For Department Use:</u></p> <p>Effective Date _____</p> <p>Approved By _____</p>
