Desk Audit
LSU Health Sciences Center – New Orleans
LSUHSC Subrecipients Monitoring Policy

Date: _____

LSUHSC Project #: _____

LSUHSC Principal Investigator: _____

LSUHSC Department: _____

Name of Federal awarding agency:_____

Award Number: _____

Subrecipient Name: _____

Subrecipient's Senior Investigator: _____

Audited Subrecipient Invoice # _____

Audited Invoice Period Covered _____

Audited Invoice Amount: _____

Attachments Needed:

Supporting documents for audited invoice ☐

Certificate of Sub-recipient Certification ☐

I certify that I have reviewed the supporting documents and the Indirect Cost and Fringe Benefit calculations invoiced to LSUHSC- NO. The expenses on the invoice are allowable, allocable, and appropriate under the guidelines of the subaward and federal award.

Print name **Signature** **Date**

Revised 12/9/15