Children's Hospital Los Angeles
Request for Indirect Cost Waiver or Cost Sharing Support

Project Title:

PI/PD: | DIV/DPT:

Prime Sponsor:

Requesting *(select all that apply)*:   IDC Waiver   Cost Share   Both

Direct Cost: $_____

Allowable IDC:_____

Recovered IDC:_____

Total amount of waiver request:

$ _____

*Please use Indirect Cost Waiver Calculator available at https://www.chla.org/research/forms-and-policies to calculate amount of waiver request and submit with your IDC Waiver Requests.

IDC Waiver

Funds used for cost sharing

Dept/Div $_____   Institution $_____

DIV/DPT account number for cost share:_____

Cost Share

Justification (attach additional documents if needed):
Please explain the value to CHLA for waiving or subsidizing the cost of this project.

By signing below, PI certifies the requested Cost Share/IDC waiver complies with CHLA policies:

_____   Signature   Date/Time Field
Print Name
Principal Investigator

_____   Signature   Date/Time Field
Print Name
Dept./Div. Head/Chair

_____   Signature   Date/Time Field
Print Name
Dept./Div. Administrator

_____   Signature   Date/Time Field
Print Name
VP, Research Operations
(Required if requesting institutional support for cost sharing or an IDC waiver)