IADR INTERNATIONAL ASSOCIATION FOR DENTAL, ORAL, AND CRANIOFACIAL RESEARCH

Wire Transfer Request Form

Name of Group/Network:	

Purpose of Payment:	
Awardee:	
Amount:	
Currency:	

Date Needed:	

Additional Info:

Approved by (Group/Network Officer):________________________ Date:_____________

To be collected by Group/Network Officer

Recipient Account Information (to):	
Beneficiary Name:	
Beneficiary Social Security/ID #:	
Beneficiary Phone #:	
Bank Name:	
Bank Address:	
IBAN#/Account #:	
IRC/Sort Code#:	
Routing # or SWIFT Code:	

For IADR Internal Use:

Initiated By: ____ Date: ______________

Approved By: ____ Date:______________