



PROJECT INFORMATION

1. Health Authority Name

[Empty text box for Health Authority Name]

2. MOH Project No.

[Empty text box for MOH Project No.]

3. Budget Fiscal Year

[Empty text box for Budget Fiscal Year]

4. Health Facility

[Empty text box for Health Facility]

5. Project Name/Description

[Empty text box for Project Name/Description]

ACCOUNT INFORMATION

6. Certificate of Approval No.

[Empty text box for Certificate of Approval No.]

7. Revision No.

[Empty text box for Revision No.]

8. Certificate of Approval Expiry Date (YYYY/MM/DD)

[Empty text box for Certificate of Approval Expiry Date]

BUDGET SUMMARY

	Certificate of Approval/ Restricted Capital Grant	RHD Funding (0.00 If N/A)	Other Funding (0.00 If N/A)	Total Budget Approved By Ministry
9. Total Approved Cost as per COA	[Empty text box]	[Empty text box]	[Empty text box]	[Empty text box]
10. Total Actual Expenditures	[Empty text box]	[Empty text box]	[Empty text box]	Total Actual Expenditures [Empty text box]
11. Variance	[Empty text box]	[Empty text box]	[Empty text box]	[Empty text box]

12. Identify sources and list amounts included in "other funding" (N/A if not applicable)

[Empty text box for other funding sources]

13. If Total Actual Expenditures are greater than approved cost, provide explanation for increase (N/A if not applicable)

[Empty text box for explanation of increase]

HA CERTIFICATION

Name (please type)

[Empty text box for Name]

Date Certified (YYYY/MM/DD)

[Empty text box for Date Certified]

MINISTRY APPROVAL

Ministry Signature

[Empty text box for Ministry Signature]

After the project is complete and all invoices have been paid, submit this form to the Capital Services Branch