


JOHNS HOPKINS HEALTH SYSTEM
PROJECTED TIMING OF EXPENSES FOR CONSULTING AND PROFESSIONAL FEES

MONTH	FISCAL YEAR	ESTIMATED TOTAL MONTHLY AMOUNT
January	FY__	\$
February	FY__	\$
March	FY__	\$
April	FY__	\$
May	FY__	\$
June	FY__	\$
July	FY__	\$
August	FY__	\$
September	FY__	\$
October	FY__	\$
November	FY__	\$
December	FY__	\$
TOTAL (Must equal projected contract amount)		\$

Departmental Approval:

Department Head: _____ Phone: _____ Date: _____

This form must accompany initial check request for payment of consulting or professional fees.