**Exhibit A SOW**

**HCP SERVICE PROVIDER INVOICE**

**(This invoice must be submitted within 30 days following the end of the quarter in which the service was provided or expense was incurred)**

 **To:** Edwards Lifesciences LLC

All invoices shall be sent via email to: THV\_Clinical\_Invoices@Edwards.com.

 **From:**

 *(name and address of Service Provider must match information in contract and W-9 on file)*

 **Invoice Date**:

|  |  |  |
| --- | --- | --- |
| **Date Service Performed** | **Description of Service(s)** | **Amount** |
|  |   |  |
|  |   |  |
|  |   |  |
|  |   |  |
|  |   |  |
|  | **Total Fees** |  |

|  |  |  |
| --- | --- | --- |
| **Date of Expense** | **Nature of Expense(e.g., hotel, airfare, meal, and whether breakfast, lunch or dinner)** | **Amount** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  | **Total Expenses** |  |
|  |  |  |
| **Total Invoice Amount** |  |

The undersigned Service Provider hereby affirms that the services listed above have been performed for Edwards, that the expenses listed, if any, were incurred by Service Provider in connection with the performance of the Services, and that copies of detailed, itemized receipts for the expenses are attached.

**Signed:** **Date:**

The undersigned Edwards employee hereby acknowledges that the above-listed Services were requested by Edwards, performed by the Service Provider to the satisfaction of Edwards, that any travel expenses were pre-approved by Edwards pursuant to the terms of the Service Provider’s contract with Edwards, and that this Invoice is approved for payment.

**Signed:** **Date:**

 Associated Edwards Contract #