



Change of Fund Custodian

Name of New Fund Custodian:

Fund Number(s) responsible for:

Effective Date:

I certify that I am the new fund custodian for the LSU Health Foundation, New Orleans fund(s) listed above.

I certify that as fund custodian, I have reviewed, and will adhere to the LSU Health Foundation's [Comprehensive Disbursement Policy](#) and [Transactional Authority Policy](#). I have also read and acknowledge the [Summary of Foundation Funds](#) document of the LSU Health Foundation.

I certify that, as fund custodian, I am and shall be responsible for the accuracy, authenticity and truthfulness of all documentation submitted and for all transaction activity.

I certify that, as fund custodian, all expenditures from above listed fund(s) adhere to the scope and donor intent of said LSU Health Foundation fund(s).

Signature of New Fund Custodian Date

Signature of Department Head/Director Date