

# INVOICE

Special Education Consulting Services

Invoice #: \_\_\_\_\_

Date: \_\_\_\_\_

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**CONSULTANT / SERVICE PROVIDER**

[Name/Business Name]

[Address]

[City, State, Zip]

[Phone / Email]

[Tax ID/EIN]

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**BILL TO (CLIENT/DISTRICT)**

[Client Name / School District]

[Contact Person]

[Address]

[City, State, Zip]

[Student Name/Reference ID]

| Date | Service Description (IEP Meeting, Evaluation, Consultation) | Rate/Hr | Qty/Hrs | Total |
|------|---|---------|---------|-------|
|------|---|---------|---------|-------|

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Subtotal: \$0.00

Travel/Expenses: \$0.00

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**Amount Due: \$0.00**

**PAYMENT INSTRUCTIONS**

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Please make checks payable to: \_\_\_\_\_

Payment due within [30] days of invoice date.

*Thank you for your commitment to student success.*