

INVOICE

University Accreditation Specialist

Invoice #: _____

Date: _____

Specialist Information:

Name: _____

Address: _____

Email: _____

Tax ID: _____

Bill To (Institution):

University: _____

Department: _____

Contact: _____

Address: _____

Description of Services (Self-Study, Site Visit, Compliance Review)	Hours/Units	Rate	Total
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Description of Services (Self-Study, Site Visit, Compliance Review)	Hours/Units	Rate	Total
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Travel & Administrative Expenses	_____	_____	_____
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Subtotal: \$ _____

Tax: \$ _____

Grand Total: \$ _____

Payment Instructions:

Please remit payment within ____ days via Bank Transfer/Check.

Account Name: _____ | Account Number: _____