INVOICE

Invoice #: _____
Date: _____

FROM (Provider):
TO (Medical Facility):

Service Description (Biohazard/Janitorial/Sanitization)	Area/Room #	Frequency	Rate	Amount

** All services performed in compliance with OSHA Bloodborne Pathogens Standards and HIPAA privacy regulations.*

Subtotal: $_____
Tax: $_____

TOTAL DUE: $_____

Payment Terms: Net ___ Days. Please make checks payable to the Provider Name listed above.
Authorized Signature: _____ **Date:** _____