

[Consulting Firm Name]

Diagnostic Lab Compliance Specialists
[Street Address]
[City, State, Zip]
[Phone / Email]

INVOICE

Invoice #: [0000]
Date: [MM/DD/YYYY]
Due Date: [MM/DD/YYYY]

BILL TO

[Client Laboratory Name]
[Contact Person / Department]
[Street Address]
[City, State, Zip]

PROJECT REFERENCE

CLIA/CAP Audit Readiness
PO #: [Optional]

Description of Services	Hours/Qty	Rate	Amount
Mock CLIA/CAP Inspection & Assessment	[0.0]	[\$[0.00]]	[\$[0.00]]
Policy & Procedure Manual Review	[0.0]	[\$[0.00]]	[\$[0.00]]
Personnel Qualification Verification	[0.0]	[\$[0.00]]	[\$[0.00]]
Quality Management System (QMS) Training	[0.0]	[\$[0.00]]	[\$[0.00]]

Subtotal: \$[0.00]
Tax (if applicable): \$[0.00]
Total Amount: \$[0.00]

Payment Terms: Net [30] Days. Please make checks payable to [Consulting Firm Name].

Thank you for your partnership in maintaining laboratory excellence and regulatory compliance.