CLINICAL SHIFT INVOICE

Invoice #: _____
Date: _____

Clinician Information:
Name:
License/ID:
Contact:
Facility Information:
Name:
Department:
Address:

Date	Shift Type (Day/Night)	Start Time	End Time	Hours	Hourly Rate	Total

Subtotal: $_____

Adjustments/Bonuses: $_____

Grand Total: $_____

Clinician Signature: _____ Date: _____

Supervisor Approval: _____ Date: _____

Payment Terms: Net 30. Please make checks payable to the clinician name listed above.