

# PARAMEDIC SERVICES

[Your Name/Provider Name]  
[Address Line 1]  
[City, State, Zip]  
[Phone/Email]

INVOICE #

DATE

**BILL TO:**

[Agency/Organization Name]  
[Contact Person]  
[Department/Station]

**PAY PERIOD:**

[Start Date] - [End Date]

Date	Shift Type / Unit #	Start	End	Hours	Rate	Total
					\$	\$
					\$	\$
					\$	\$
					\$	\$

Subtotal: \$ \_\_\_\_\_

Adjustments/Expenses: \$ \_\_\_\_\_

**Total Due: \$** \_\_\_\_\_

---

**PAYMENT INSTRUCTIONS:**

Please make checks payable to **[Your Name]** or transfer via [Bank Info/App].  
Due within [Number] days of receipt.

*Thank you for your professional partnership.*