INVOICE

Radiology Technician Services

[Technician Name]

[License Number]

[Address / Phone]

Bill To:
[Facility/Hospital Name]
[Department/Unit]
[Address]

Invoice #: ____________
Date: ____________
Period: ____________

Date	Facility/Modality	Shift Start	Shift End	Break	Hours	Rate	Total

Subtotal: $0.00
On-Call/Stipends: $0.00
Amount Due: $0.00

Technician Signature

Supervisor Approval

Please make checks payable to: **[Payment Name]**

Payment Terms: Net [30] Days