MEDICAL ASSOCIATION

123 Healthcare Blvd, Medical District
City, State, Zip Code
contact@medicalassociation.org

INVOICE

Invoice #: _____
Date: _____

Bill To:
Name: _____
License #: _____
Address: _____
Email: _____
Subscription Period:
Start Date: _____
End Date: _____
Member Status: _____

Description	Quantity	Unit Price	Total
Annual Professional Membership Dues	1	$	$
Journal Subscription (Print & Digital)	1	$	$
CME Portal Access Fee	1	$	$

Description	Quantity	Unit Price	Total
Administrative Fees	1	$	$

Total Amount Due: $ _____

Payment Instructions: Please make checks payable to "Medical Association" or pay via the member portal. Payments are due within 30 days of the invoice date.

Thank you for your continued dedication to the medical profession.