COMMISSION INVOICE

[Consultant Name/Firm]
[Street Address]
[City, State, Zip]
[Tax ID/NPI Number]

Invoice #: [00000]
Date: [MM/DD/YYYY]
Due Date: [MM/DD/YYYY]

BILL TO:

[Healthcare Facility/Client Name]
[Department/Attn]
[Street Address]
[City, State, Zip]

PROJECT/REFERENCE:

[Project Name/Contract ID]
[Commission Period Start] - [Commission Period End]

Placement/Service Description	Revenue Generated	Commission Rate	Amount
[Candidate Placement / Contract Value]	$0.00	0.0%	$0.00
[Healthcare Management Consulting Fee Share]	$0.00	0.0%	$0.00
[Other Performance Incentive]	-	-	$0.00

Subtotal: $0.00
Tax (if applicable): $0.00
Total Due: $0.00

Payment Instructions:
Bank Name: [Name]
Account Number: [Number] | Routing Number: [Number]
Please include Invoice # on all remittances.