

COMMISSION INVOICE

[Healthcare Agency Name]
[Address Line 1]
[City, State, Zip]
[Email/Phone]

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

BILL TO: [Client Facility Name]
[Contact Name / Dept]
[Address Line 1]
[City, State, Zip]
PLACEMENT CONSULTANT / RECRUITER: [Recruiter Name]
[ID Number]
Billing Period: [Start Date] - [End Date]

Healthcare Provider Name	Staffing Type	Total Hours/Shift	Bill Rate	Commission Rate (%)	Amount
[Full Name, Title]	[RN / LPN / CNA / Locum]	[0.00]	[\$[0.00]]	[0.0]%	[\$[0.00]]
[Full Name, Title]	[RN / LPN / CNA / Locum]	[0.00]	[\$[0.00]]	[0.0]%	[\$[0.00]]

Subtotal: \$[0.00]
Service Fees / Adjustments: \$[0.00]
Total Commission: \$[0.00]

Payment Instructions:
Please make checks payable to [Agency Name] or remit via ACH to Account: [Number] Routing: [Number].

Thank you for your partnership in healthcare staffing excellence.