[Nonprofit Name]

[Street Address]
[City, State, Zip]
[Tax ID / EIN]

INVOICE

Invoice #: [000]
Date: [MM/DD/YYYY]

CONTRIBUTOR / BILL TO

[Contact Name/Organization]
[Street Address]
[City, State, Zip]
[Email/Phone]

PROJECT DETAILS

Project: [Health Project Name]
Phase: [e.g., Clinical/Outreach]
Manager: [Name]

Description of Contribution	Units/Qty	Rate/Value	Total
[Project Service or Resource Description]	[0.00]	$[0.00]	$[0.00]
[Project Service or Resource Description]	[0.00]	$[0.00]	$[0.00]

Subtotal: $[0.00]
Tax/Fees: $[0.00]
Amount Due: $[0.00]

Payment Instructions: [Bank Name] | [Account Number] | [Routing Number]

Thank you for supporting our health initiatives. Please note that contributions to this 501(c)(3) project may be tax-deductible to the extent allowed by law.