[Nurse Name/Agency]
[Street Address]
[City, State, Zip]
[Phone Number]

INVOICE

Invoice #: _____
Date: _____

BILL TO

[Patient/Client Name]
[Street Address]
[City, State, Zip]

SERVICE PERIOD

Start Date: _____
End Date: _____

Date	Service Description / Nurse Name	Hours	Hourly Rate	Total

Subtotal: $_____

Tax / Adjustments: $_____

Total Amount Due: $_____

Notes: Please make checks payable to _____. Payment is due within ____ days.