

NURSING INVOICE

Invoice #: _____

Date: _____

CONTRACTOR INFORMATION
[Your Name/Business Name]
License #: [RN/LPN Number]
[Street Address]
[City, State, Zip]
[Phone/Email]

BILL TO:

[Facility/Client Name]

[Department/Contact Person]

[Street Address]

[City, State, Zip]

PAYMENT TERMS:

Due Date: _____

Payment Method: _____

Date	Shift/Description of Services	Hours	Rate (\$)	Total (\$)
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Subtotal: \$ _____

Reimbursables/Expenses: \$ _____

Total Amount Due: \$ _____

NOTES / INSTRUCTIONS

Please make checks payable to **[Your Name/Business Name]**.

Thank you for your business.