

INVOICE

Law Firm Name: [Firm Name]
Address: [Street, City, State, Zip]
Email: [Email Address]

Invoice #: [0000]
Date: [MM/DD/YYYY]
Matter Ref: [Case Number]

Client:
[Client Full Name]
[Client Address]
[City, State, Zip]
Subject:
Disability Discrimination Claim
vs. [Opposing Party Name]

Date	Description of Services	Hours	Rate	Total
[Date]	Initial Consultation & Case Evaluation	[0.0]	[\$0.00]	[\$0.00]
[Date]	Drafting Demand Letter / EEOC Filing	[0.0]	[\$0.00]	[\$0.00]
[Date]	Review of Medical Evidence & Accommodation Requests	[0.0]	[\$0.00]	[\$0.00]
[Date]	Legal Research: [Specific Statute/ADA Provision]	[0.0]	[\$0.00]	[\$0.00]

Date	Description of Services	Hours	Rate	Total
[Date]	Communication with Client/Opposing Counsel	[0.0]	[\$[0.00]]	[\$[0.00]]

Subtotal: \$[0.00]

Administrative/Filing Fees: \$[0.00]

Total Amount Due: \$[0.00]

Payment Terms: Due within [30] days. Please make checks payable to "[Firm Name]".

This invoice is for legal services rendered in connection with disability discrimination litigation/mediation.