

Consultant/Vendor Name

Address Line 1
Address Line 2
Contact Phone# or Email
Attn:

INVOICE

Invoice # :

DATE:

CUSTOMER NAME: BC PROVINCIAL RENAL AGENCY
ADDRESS: 700 -1380 BURRARD STREET
VANCOUVER, BC
V6Z 2H3

PLEASE REMIT UPON RECEIPT

DESCRIPTION OF SERVICES RENDERED & EXPENSES

PROFESSIONAL SERVICES RENDERED FOR THE PERIOD COVERING:

START DATE	<input type="text"/>
END DATE	<input type="text"/>

HOURS WORKED	HOURLY RATE	NET	GST <small>*If Applicable*</small>	TOTAL
SERVICES RENDERED	<input type="text"/>	0.00	<input type="text"/>	0.00

DETAILS OF SERVICES

GST #

OTHER EXPENSES (PLEASE ATTACH ORIGINAL RECEIPTS):

DESCRIPTION / UNITS (KM)	AMT.	GST	TOTAL
TRAVEL, MEALS, AND ACCOMMODATION	<input type="text"/>	<input type="text"/>	0.00
OTHER / MISC.	<input type="text"/>	<input type="text"/>	0.00
MILEAGE (KM)	0.00	0.00	0.00

***Mileage rates are \$0.52 / KM

<input type="text"/>	<input type="text"/>	GRAND TOTAL	0.00
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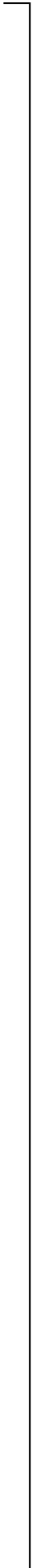
Consultant/Vendor Name

Signature

FOR BCPRA & PHS A USE ONLY

BU	FUND	ACCOUNT	DEPARTMENT	SITE	PROJECT	COST	GST	TOTAL
015				099				0.00
015				099				
015				099				
015				099				





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