BUREAU OF HEALTH SERVICES
INVOICE FOR DPA VENDOR REIMBURSEMENT

NAME AND ADDRESS OF VENDOR	COUNTY NAME
	PERIOD SERVICE PROVIDED
	FROM TO
	ALLOTMENT CODE AND COST CENTER
SOCIAL SECURITY #	
TYPE OF SERVICE PROVIDED	CONTRACT NUMBER

DATE SERVICE PROVIDED (MONTH/DAY/YEAR)	NUMBER OF HOURS WORKED	HOURLY RATE OF REIMBURSEMENT	TOTAL	ALLOTMENT CODE AND COST CENTER
TOTAL DUE VENDOR				

VENDOR'S SIGNATURE

_____

DATE _____

I hereby certify the data above to be true and correct and payment is due the above-named vendor.

RECOMMENDED FOR PAYMENT

CONTRACTING STATE AGENCY'S AUTHORIZED CERTIFICATION

_____

TITLE_____

DATE _____