

Invoice

| | |
|---------------|----------------|
| Date Invoiced | Invoice Number |
| | |

Bill To:

WV Division of TB Elimination
Office of Epidemiology and Preventive Services
350 Capitol Street, Room 125
Charleston, WV 25301-3715

| Item | Description | Qty. (hours) | Rate | Amount |
|------------|--|--------------|-------------|--------|
| TB Control | Tuberculosis Control Program, [Date of service] | <hr/> | X \$20.00 = | |

| | |
|--------------|----|
| Total | \$ |
|--------------|----|

I CERTIFY THAT THIS IS THE ORIGINAL INVOICE AND THAT PAYMENT HAS NOT BEEN RECEIVED.

Local Health Dept. Signature --