INVOICE

Consultant/Vendor Name
Address Line 1
Address Line 2
Contact Phone# or Email
Attn:

Invoice # :	
DATE:	

CUSTOMER NAME: BC RENAL
ADDRESS: 260 - 1770 W 7th Ave.
VANCOUVER, BC
V6J 4Y6

PLEASE REMIT UPON RECEIPT

DESCRIPTION OF SERVICES RENDERED & EXPENSES

PROFESSIONAL SERVICES RENDERED FOR THE PERIOD COVERING:

START DATE	
END DATE	

	HOURS WORKED	HOURLY RATE	NET	GST *If Applicable*	TOTAL
SERVICES RENDERED					

DETAILS OF SERVICES

GST #

OTHER EXPENSES (PLEASE ATTACH ORIGINAL RECEIPTS):

	DESCRIPTION / UNITS (KM)	AMT.	GST	TOTAL
TRAVEL,MEALS, AND ACCOMODATION				
OTHER / MISC.				
MILEAGE (KM)				

***Mileage rates are $0.70 / KM

GRAND TOTAL

Consultant/Vendor Name　　Signature

FOR BCPRA & PHSA USE ONLY

BU	FUND	ACCOUNT	DEPARTMENT	SITE	PROJECT	COST	GST	TOTAL
015				096				
015				096				
015				096				
015				096				