# INVOICE

**NAME:** ______________________________________________ **CATEGORY:** ______________________
*(Please Print)*

**ADDRESS:** ____________________________________________________________________________

**CITY:** ______________________ **PROV:** ____________________ **POSTAL:**____________________

**SIN:** __________________________________ **HST:** __________________________________________
*(Social Insurance Number)*

**INVOICE NUMBER:** _______________________________________

**DATE:** ________________________________________________

**DENTAL OFFICE:** _________________________________________

**ADDRESS:** _____________________________________________

**CITY:** ___________________ **PROV.:** ______________________

**POSTAL:** ________________ **PHONE:**______________________

**TERMS: PAYMENT UPON RECEIPT**

| DATE WORKED | HOURS | UNPAID BREAK | TOTAL HOURS | BILL RATE/HR | TOTAL BILLED |
|---|---|---|---|---|---|
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| | | | | | |
| | | | | | |
| | | | | **TOTAL** | $ |

Please make cheque payable to:

Name: ____________________________