

TO: Department of Health
BUREAU OF OPERATIONS
PRACTITIONER REPORTING & EXAMINATION SERVICES

INVOICE # _____

INVOICE FOR SERVICES

NOTE: This form must be submitted only for payment for your hourly-salaried services. It should not be used for travel or other kinds of reimbursements. All applicable areas **MUST** be filled in. **YOU MUST LIST EACH DATE INDIVIDUALLY.** Your name, signature, rate of pay, and Social Security or FEID number should appear as stated on your purchase order. If you need additional space, please use additional forms and **sign each form.** Please **return this form** to the address below **within 14 days of completion of services.**

Name: _____ Social Security # or FEID #: _____

Address: _____

Telephone: Home _____ Work _____ Fax _____

Email address: _____

Type of Service: (Please check the appropriate box)

EXAMINER CONSULTANT OTHER _____

(Specify: e.g., expert witness, translator, ADA, etc.)

Services for the profession of: _____
(e.g., Dentistry, Chiropractic, Optometry, Hearing Aid Specialist)

DATE(S)	DESCRIPTION OF SERVICES PERFORMED	NO. OF HOURS WORKED

TOTAL HOURS WORKED = _____

RATE OF PAY = \$ _____

EXAMINER/CONSULTANT SIGNATURE

TOTAL AMOUNT DUE = \$ _____

FOR OFFICIAL USE ONLY

PSYCHOMETRICIAN APPROVAL

DATE

PURCHASE ORDER NUMBER

MAIL TO:
PRES/Dept. of Health
Psychometrician
4052 Bald Cypress Way, BIN # C-90
Tallahassee, Florida 32399-3290

FINAL INVOICE YES NO