INVOICE

Invoice Date	Invoice Number				

Service Prov	<u>/ider Name</u>	• •				
Mailing Addı	ress:					
City:			Postal Code:			
Phone Numl	ber:()	<u>-</u>		_		
If payee is dif	ferent from a	above complete this	section			
Payee Name	ə:					
Mailing Addı	ress:					
City:				Postal Code:		
Phone Numl	ber:(<u>-</u>		_		
Bill To:	Ministry of PO Box 97	nding Branch Children and Famil 76 STN PROV GO C V8W 9S5		ment		
Billing Numb	er:					
Client Name	(Child):					
Month Servi	ce Provided	d:				
Type of Se	Service	Dates	# of Hours	Rate Per Hour inclusive of PST if applicable	Total Amount	
				\$	\$	
		TOTAL SERVICE	S		\$	
		TOTAL GST / HS	\$			
		TOTAL INVOICE AMOUNT			\$	

Service Provider Signature

Parent Signature