**SAMPLE FORMAT FOR INVOICE**

DATE: March 3, 2010

# Top Health Care

TOP HEALTH CARE

Rural, WY 55555

Phone: 555-555-5555

Fax: 222-222-2222

Email: xyz@example.com

Website: http://mysite@example.com

TO: Michelle Hoffman, Program Manager

Office of Rural Health

6101 Yellowstone Road, Suite 259B

Cheyenne, WY 82002

FROM: Sam Jones, Director

Top Health Care

REFERENCE: REACH Program

Date of your event

Request for reimbursement as follows: (Total amount allowable for grant = $2,000.00)

|  |  |
| --- | --- |
| **EXPENSES** | **COST** |
| **Transportation** |  |
| Driver Stipends ($100 x 2) | $200.00 |
| Fuel | $50.00 |
| **Food for Students and Helpers** |  |
| AM snacks ($2.50 x 32) | $80.00 |
| Lunch ($5.95 x 32) | $190.40 |
| PM Snacks ($2 x 32) | $64.00 |
| **Site Coordinator** |  |
| Plan, coordinate, travel, supervision | $500.00 |
| **Supplies/Program Expenses** |  |
| Gloves | $9.89 |
| Glucose Testing | $51.13 |
| Blood Pressure Kits and Thermometers | $29.98 |
| Disability Equipment | $128.00 |
| **Communications** |  |
| Student Folders ($0.17 x 28) | $4.76 |
| Postage ($0.43 x 150) | $64.50 |
| Copies | $32.20 |
| Newspaper & Radio | $50.00 |
| **TOTAL AMOUNT OF THIS REQUEST** | **$1,454.86** |

Please contact Sam Jones at (907) 335-2134, if you have any questions regarding this invoice.

Thank you,

Jane Doe

Accounting Director

*NOTES: Please submit your invoice on your organization’s letterhead. Please attach any backup forms to substantiate the charges, such as receipts or other documentation. Please clearly delineate the amount of your request.*