Company Name: _____

Name: _____
Street Address: _____
City, State: _____
ZIP Code: _____
Phone: _____
E-mail: _____

MEDICAL EXPERT WITNESS INVOICE

Invoice # _____ Date: _____

Client / Customer
Name: _____
Street Address: _____
City, State: _____
ZIP Code: _____

Description	Hours	$ / Hour	Amount ($)

Comments or Special Instructions:

_____

Payment is due within ____ days.

SUBTOTAL	
DISCOUNT	
TAX	
TOTAL	

Thank you for your business!