46540 Fremont Blvd, Suite 514
Fremont, CA 94538

INVOICE FOR PARAMEDICAL EXAMINATION SERVICES

Examiner Name / Id: _____ **Invoice Date:** _____

Address: _____ **Signature:** _____

_____ **SSN:** _____

Case Number	Exam Completion Date	Applicant Name Last, First Middle	Procedure Code#	Bar Code Number	Fee Charged ($)

ALL INVOICES ARE DUE BY 15TH AND 30TH OF EVERY MONTH!