Physician Services Invoice

Physician Name: _____

Clinic: _____ **Phone number:** _____

Please submit by the 15th of each month for reimbursement.

Fax to 403-960-0039 (Local fax except for Carstairs and Didsbury)

Date	**Meeting / Survey** (please describe)	**Hours**

_____ _____

Physician Signature Date

Internal use only		
Total Hrs:	Rate: $	Total Reimbursement Approved: $

_____ _____ _____

Approver Name Approver Signature Date

101, 217 Centre Ave, Airdrie AB, T4B 3L8 |office (587) 287-1727|fax (403) 960-0039