Consultant Invoice

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| --- | --- | --- |
| **From:**  Your Company Name  Address  City, State, Zip Code  Telephone Number  Email address | **To:**  NACDD  2200 Century Parkway, suite 250  Atlanta, GA 30345  770-458-7400  Ap.nacdd@chronicdisease.org | **Invoice Date:**  **Invoice#:**  **Invoice Billing Period:** |

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| --- | --- | --- |
| **Description of work completed or type of expense** | **Program Finance Code**  (Program#, Project#, and Grant Year) | **Billing Amount** |
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| Invoice Total |  |  |