Client:	**Compassionate Care Unlimited, Inc.** INVOICE STATEMENT*
IC Signature:	
Nurse Name:	Nurse Title: RN☐ LPN☐ NA☐
ID #:	COVID Testing x 1 ☐ <24 hours
Date:	COVID Testing x 2 ☐ >24 hours *(IF APPLICABLE)*

Day of Week	Date	Task Start Time	Time Off Job Site	Task End Time	Hrs.	Auth. Initial	Total Hours	Client/ Facility Initials	Extra Fee Hours
				Invoice Totals					

Facility Signature: **Date:**

***All invoice statements received after 9:00 AM on Monday's, will be processed the following week. ©2021**

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