Complete the shaded fields.

CONSULTANT'S INVOICE

FOR MDH USE ONLY
Purchase Order Number:

Payable to: (please print)

Name	Social Security Number
Billing Address	Federal ID Number
City State ZIP	State Tax ID Number

Date	Location	Detailed Description of Service Performed
	Hospital name and city	"Trauma system designation application review, site visit and report to State Trauma Advisory Council"

Calculation of Fees and Expenses

Fee for Professional Services	$750.00 or $1,250.00

Mileage Calculation

Date	From	To	Total Miles	Mileage Rate	Mileage Reimbursement
	Your home or work	Hospital city	Mileage	$0.535	$
	Hospital city	Your home or work	Mileage	$0. 535	$
				$0. 535	$

Total Mileage Expense	$
Total Air Fare Expense *From to (attach receipt)*	$
Total Parking Expense	$
Total Car Rental Expense *(attach receipt)*	$

Calculation of Meals Expense

Date	Actual Cost for Breakfast	Actual Cost for Lunch	Actual Cost for Dinner	Total
	$ $9 max.	$ $11 max.	$ $16 max.	$ $36 max.
	$	$	$	$
	$	$	$	$

Total Meals Expense	$
Total Lodging Expense *(attach receipt)*	$
Grand Total Reimbursement Requested for Fees and Expenses	$

Certification

I hereby certify that I have performed the services described above and therefore request payment.

Consultant's Signature Date

I hereby certify that services indicated above have been performed in accordance with the agreement and approve payment for these services.

MDH Supervisor's Signature Date

DISTRIBUTION:
Original: MDH Financial Management
Copy: MDH Program
Copy: Consultant

HE-01233-12 (01/06)

SAMPLE