DENTIST INVOICE

DATE: ________________

Name: ____

Address: ____

City: ____________________ State ______________ Zip __________

Phone: ________________________

SS# or EIN# ________________________

Fax invoice to Southern Crescent Personnel:

Services Performed:

Day	Date	Client Location	Time in	Time taken for Lunch Break	Time out	Total Hours
MONDAY						
TUESDAY						
WEDNESDAY						
THURSDAY						
FRIDAY						
SATURDAY						
SUNDAY						

Signature: ________________________

Date: ________________________

Mail payment: ☐

Hold Payment for Pickup: ☐

*Refer a Friend and receive a Referral Bonus!!! (from $50.00 to $250.00 per person). Call for details.

Aka dental timesheet