***Healthcare Workforce Loan Repayment Program***

***Invoice***

**YOUR NAME & HOME Address Invoice #:**

**1234 Easy Street**

**Somewhere, UT 84532**

**xxx-xxx-xxxx Phone**

**EMAIL**

Invoice for:

**Healthcare Workforce Loan Repayment Program FY23**

**Attn:** Rachel Devine **Issue Date:**

Subject: **Healthcare Workforce Loan Repayment Program**

|  |  |  |
| --- | --- | --- |
| Description |  |  |
| Payment for work performed according to contract obligation for the time period :  |  |  |
|  | Amount Due | $ |

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Hospital/Clinic/Site: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_