|  |  |
| --- | --- |
| **[Company Name]**  Name: [Name]  Street Address: [Street Address]  City, State: [City, State]  ZIP Code: [ZIP Code]  Phone: [Phone]  E-mail: [E-Mail] | **MEDICAL EXPERT WITNESS INVOICE** |

|  |  |
| --- | --- |
| **Invoice # [No]** | **Date: XX, XX, XXXX** |

**Client / Customer**

Name: [Name]

Street Address: [Street Address]

City, State: [City, State]

ZIP Code: [ZIP Code]

|  |  |  |  |
| --- | --- | --- | --- |
| **Description** | **Hours** | **$ / Hours** | **Amount ($)** |
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|  |  |  |  |
| [Comments or Special Instructions] |  | SUBTOTAL |  |
|  |  | DISCOUNT |  |
|  |  | TAX |  |
| **Payment is due within [Number (#)] days.** |  | **TOTAL** |  |