# **SP Information**

Name:

Address:

Date of Activity:

Invoice #:

*(Please note this must be a unique number for each invoice submitted)*

# **Billing Information**

Bill to:

Bon Secours Clinical Simulation Center

Richmond Higher Education Institutes

8550 Magellan Parkway

Suite 1100

Richmond, VA 23227

ATTN: Holly Pugh

# **Services Provided**

|  |  |  |  |
| --- | --- | --- | --- |
| **Activity** | **# Hours** | **Rate** | **Amount** |
|  |  |  |  |
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| **Total:** |  |  |  |