Arizona Alliance
FOR COMMUNITY HEALTH CENTERS
Primary Healthcare for All

Invoice

Invoice Number: _____

Date: _____

From:

Name of Organization: _____

Payment Address: _____

TO:

Arizona Alliance for Community Health Centers
700 East Jefferson Street, Suite 100
Phoenix, AZ 85034

Due Date	Description	Total
Due Upon Receipt		

Please provide documentation of expenses paid or receipts for items being billed for reimbursement.

I confirm that by submitting this report/invoice, I certify to the best of my knowledge and belief that the report/invoice is true, complete, and accurate, and the expenditures, disbursements, and cash receipts are for the purposes and intent set forth in the award/contract documents and in compliance with UGG 2 CFR Part 200.

Signature: _____