Doulas for
Aboriginal Families
Grant Program

INVOICE

Doula name:

Address:

City, province:

Postal code:

Phone:

Email:

Date:

Client name:

Invoice #:

(Doulas must provide an invoice #)

BILL TO

BC Association of Aboriginal Friendship Centres
551 Chatham Street, Victoria, BC, V8T 1E1
Phone: 250-388-5522

Date of Service	Service(s) Provided	Hours	Amount
		TOTAL ($):	

Services with client completed on (date):

Please complete the birth story summary and signature portion on page 2.

Incomplete invoices will not be accepted. Please allow up to 30 days for cheque to be delivered.

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INVOICE

Summary of Birth Story

Summary of birth story: *(Birth stories help demonstrate the importance of the program. What were some of the best moments working with your client? How did your services improve your clients experience? Identifying information is kept confidential.)*

Please check all that apply:

☐ Vaginal birth ☐ Instrumental birth ☐ Caesarean section ☐ Narcotics use ☐ Epidural use

Location of birth:

☐ Home ☐ Hospital, city/town: ☐ Other:

Signatures

Name of doula (please print):	
Signature:	Date (MM/DD/YYYY):
Name of client (please print):	
Signature:	Date (MM/DD/YYYY):

Please know we may contact the client if we have any questions about the services provided.