Doulas for
Aboriginal Families
Grant Program

INVOICE

Client name:

Doula name:

Address:

City, province:

Postal code:

Phone:

Email:

Date:

Invoice #:

(Doulas must provide their 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.

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INVOICE

Summary of Full Spectrum Support
Full Spectrum Support Story: *(Your support stories help demonstrate the importance of the program. What were some of the best moments working with this family? How did your services improve this family's experience? Identifying information is kept confidential.)*

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. You will receive email confirmation upon receipt of your invoice. Please allow up to 30 days for processing.	

BCAAFC | BC Association of Aboriginal Friendship Centres

First Nations Health Authority
Health through wellness

British Columbia | Ministry of Health