



**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
<b>TOTAL (\$):</b>			

Services with client completed on (date):

**Please complete the birth story summary and signature portion on page 2.**  
Incomplete invoices will not be accepted.



## Summary of Birth Story

**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.)*

**Please check all that apply:**

Vaginal birth     Instrumental birth     Caesarean birth     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.

