Doulas for
Aboriginal Families
Grant Program

# INVOICE

| Doula name: |
|---|
| Address: |
| City, province: |
| Postal code: |
| Phone: |
| Email: |

| Client Name: |
|---|
| Date: |
| Invoice #:<br>(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 |
|---|---|---|---|
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| | | **TOTAL ($):** | |

Services with client completed on (date):

**Incomplete invoices will not be accepted. Please complete page 2. Support story summaries are optional.**

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## Full Spectrum Support Summary

**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).*

**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. | |

BCAAFC | BC Association of Aboriginal Friendship Centres

First Nations Health Authority
Health through wellness

BRITISH COLUMBIA Ministry of Health