



Provider Invoice
Disability Services

Meier Hall, First Floor, Room 102

978-542-6217(V) 978-542-7146(TTY) Fax: 978-542-2064

Name: _____ **Week Ending:** _____

Address: _____ **SS #** _____
Certification _____

Signature: _____ **Fee/Hour** _____

Date/s	Exact Class Time/s		M, T, W, TH, F	Student Initials	Code & Course #	# Billable Hours to the nearest 1/2 hr	Codes
					CL:		CL: Classroom LAB: Classroom Lab
					CL:		SE: Special Event W: Workshop
					CL:		P: Practicum PM: Professor Meeting
					CL:		T: Tutoring Session
					CL:		SG: Small Group Meeting
							O: Other/Explain:

Number of billable hours _____

Total \$ request for week _____ **\$** _____

Director's Signature

Date