Dr. (please insert first & last name)	**INVOICE** INVOICE #ROMP001 Date: September 17, 2008

BILL TO:	Rural Ontario Medical Program 459 Hume Street Collingwood, ON L9Y 1W9 705-445-7667 877-445-7667	**REMITANCE ADRESS:**	

DESCRIPTION	TOTAL
Preceptor for (list learner(s)) from (date of rotation)	1,000.00
NOTE: ALL CHEQUES MUST BE PAID IN CANADIAN FUNDS. **TOTAL DUE**	$1,000.00

Signature: _____ Printed Name: _____

Please make all checks payable to Dr.