SPECIAL EDUCATION CONSULTANCY SERVICES

PROFESSIONAL EDUCATIONAL ADVOCACY & CONSULTING

Consultant Name: _____

Address: _____

Phone/Email: _____

Tax ID / EIN: _____

INVOICE

Invoice No: _____

Date: _____

Due Date: _____

BILL TO

Client / School District: _____

Contact Person: _____

Address: _____

Email: _____

Phone: _____

STUDENT INFORMATION

Student Initials / ID: _____

Grade / Program: _____

Case Manager: _____

Reference (e.g., IEP Meeting): _____

Subtotal: _____

Travel / Expenses: _____

Total Due: _____

Consultant Signature

Authorized Client Approval / Receiver

PAYMENT TERMS & INSTRUCTIONS

1. Payment is requested within _____ days of the invoice date.

2. Please make checks payable to: _____

3. For electronic bank transfers: Routing #: _____ Account #: _____

Thank you for your partnership in supporting professional specialized educational solutions.