

**2020 - 2025 BLS Invoice – Agencies that operate an MIH program**

Fire Agency Name  
Exhibit: C – Invoice and Budget Summary  
Contract Period: 1/1/2020 to 12/31/2025

Fire Agency Name  
Address 1  
Address 2  
Name, Title  
(111) 111-1111  
[email@email.com](mailto:email@email.com)

EMS Division Invoice Contact (Please signed PDF of invoice to:  
Kristine Mejilla ([Kristine.Mejilla@kingcounty.gov](mailto:Kristine.Mejilla@kingcounty.gov))  
Public Health—Seattle & King County  
Emergency Medical Services Division  
401 5<sup>th</sup> Ave., Suite 1200  
Seattle, WA 98104

ALL FIELDS MUST BE COMPLETED FOR PROMPT PAYMENT PROCESSING

King County Accounts Payable Information	
Purchase Order #	_____
Supplier Name	_____
Supplier #	_____
Supplier Pay Site	_____
Remit to Address	_____
Invoice Date	_____
Invoice #	_____
Amount to be Paid	_____
Note to AP	_____
Payment Type	(Circle One) CHECK or ACH
Print on Remittance	_____
PH Program Name & Phone	_____

Invoices for services rendered under this contract for the period of:

Start Date	End Date
MM/DD/YY	MM/DD/YY

For Public Health Use Only				
	Rcv'd	FM Review	Entered	Approved
Date				
Initial				

Project	Organization	Expend Acct	Task	Award	DPH Acct	CPA	CFDA	Amount

Attach sheet for multiple POETAs

Direct Costs	Budget	Billed to Date	Current Report	Cumulative	Balance
<b>Personnel Costs</b>	\$	\$	\$	\$	\$
Salaries	--	--	\$	\$	--
Overtime	--	--	\$	\$	--
Benefits	--	--	\$	\$	--
<b>Program Support</b>	\$	\$	\$	\$	\$
Supplies & Uniforms	--	--	\$	\$	--
Planning	--	--	\$	\$	--
Training	--	--	\$	\$	--
<b>Vehicle/Vehicle Support</b>	\$	\$	\$	\$	\$
<b>Technology/Reporting</b>	\$	\$	\$	\$	\$
<b>Professional Services</b>	\$	\$	\$	\$	\$
<b>Total Direct Costs</b>	\$	\$	\$	\$	\$

<b>Grand Total</b> (Your agency's portion)	\$	\$	<b>\$</b>	\$	\$
			Amount Due		

I, the undersigned, do hereby certify under the laws of the State of Washington penalty of perjury that this is a true and correct claim for reimbursement services rendered. I understand that any false claims, statements, documents, or concealment of material fact may be prosecuted under applicable Federal and State laws. This certification includes any attachments which serve as supporting documentation to this reimbursement request.

Signed \_\_\_\_\_ Date \_\_\_\_\_

PH Program Manager Approval \_\_\_\_\_ Date \_\_\_\_\_