



ALBUQUERQUE AREA INDIAN HEALTH BOARD. INC.

7001 Prospect Place NE
Albuquerque, NM 87110
Telephone: (505) 764-0036
Facx: (505) 764-0446



INVOICE

Subawardee: _____
Address: _____

Contact: _____
Phone: _____
Email: _____
Invoice Date: _____
Invoice No.: _____

Award/Budget Period: _____
Period of Expenditures: _____
Amount of Expenditures for Period: _____

<u>Description</u>	<u>Budget</u>	<u>Current Period Expenditures</u>	<u>Prior Period Expenditures</u>	<u>Cumulative Expenditures</u>	<u>Unexpended Balance</u>
Salaries/Benefits	\$2.00	\$1.00	\$0.00	\$1.00	\$1.00
Supplies	\$2.00	\$1.00	\$0.00	\$1.00	\$1.00
Travel	\$2.00	\$1.00	\$0.00	\$1.00	\$1.00
Other	\$2.00	\$1.00	\$0.00	\$1.00	\$1.00
Contractual	\$2.00	\$1.00	\$0.00	\$1.00	\$1.00
Indirect Cost	\$2.00	\$1.00	\$0.00	\$1.00	\$1.00
TOTAL:	\$12.00	\$6.00	\$0.00	\$6.00	\$6.00

AMOUNT DUE: \$6.00

Notes: _____

Certification :

I certify to the best of my knowledge and belief that the above information is true, complete, and accurate, and the expenditures, disbursement, and cash receipts are for the appropriate purposes and objectives in accordance with the terms of the program agreement/contract, and that no part of this report has been previously paid.

Signature: _____
Name: _____
Title: _____
Phone: _____
Date: _____

AAIHB USE	
<input type="checkbox"/>	Completed invoice
<input type="checkbox"/>	General Ledger/Journal Vouchers attached
<input type="checkbox"/>	Narrative report
<input type="checkbox"/>	If requested, Budget Mod form
Reviewed by: _____	Date: _____