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| Name:Vendor Number: Address: Phone:Email address:  | INVOICEMonth & Year:  |
| To:Oregon Health Authority**Attn: Patricia Alderson** Oregon Consumer Advisory Council 500 Summer Street NE Salem, OR 97301 |  |

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| Please submit completed invoice to: **Patricia.ALDERSON@dhsoha.state.or.us** **Please mark the appropriate box below:**☐ I **am** compensated by my employer for time spent performing services as a committee member.☐ I **am not** compensated by my employer for time spent performing services as a committee member.  |

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| Date | DESCRIPTION | Hours | **Rate $155 per day** | TOTAL |
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|  | Total Due |  |  | $ |

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Make all checks payable to Name:

Please type your initials here to confirm the above information: \_\_\_\_\_