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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: \_\_\_\_\_