**INVOICE/CREDIT NOTE FOR TRANSLATION SERVICE**

**NB: All invoices must be sent within one month of the original invoice (from Language Shop to the NEL Pharmacy) and after the service has been received.**

**Invoice No.**

**Invoice Date**

|  |  |
| --- | --- |
| **Bill To:**  Pharmacy Optometry and Dental Commissioning Hub Team  NHS North East London Integrated Care Board  4th Floor Unex Tower  5 Station Road  Stratford  London E15 1DA | **Bill From:**  Add ODS Code:  Add Contractor Name:  Add Trading Name:  Add Address & Postcode: |

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| --- | --- | --- | --- | --- | --- | --- |
| **Date of Use of the service** | **Total Cost** | **Language translated** | **Pharmacy service(s) requiring translation**  **(e.g. Pharmacy First Consultation)** | **Was this for an NHS service provided?** | **Copy of original invoice attached?**  **(Y/N)** | **Date of original invoice from Language Shop** |
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