**INVOICE for Disposal of Clinical Sharps Service**

Contractor Name…………………………………………………………………………………………………………………………………

Email……………………………………………………………………………………………………………………………………………………

Telephone Number………………………………………………………………………………………………………………………………

I, the above contractor request payment of £……………………………\* from:

Cambridge City Council

East Cambridgeshire District Council

Fenland District Council

Huntingdonshire District Council

Peterborough City Council

South Cambridgeshire District Council

For providing the Disposal of Clinical Sharps service at the below pharmacy premises

Pharmacy Name…………………………………………………………………………………………………………………………………

ODS Code…………………………………………………………………………………………………………………………………………..

Address………………………………………………………………………………………………………………………………………………

……………………………………………………………………………………………………………………………………………………………

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During the period of ………./………./………. to ………./………./……….

Signed………………………………………………………………………………………………………………………………………………….

Print Name…………………………………………………………………………………………………………………………………………

Date…………………………………………………………………………………………………………………………………………………….

*\*Payment is £600 annually (per pharmacy site) or £50 per month in the event the service was not delivered for the full year.*