**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………………………………………………………………………………………………………………………………………………

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

…………………………………………………………………………………………………………………………………………………………….

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.*