LAB Louisiana Association for the Blind

Low Vision Rehabilitation Center
1714 Claiborne Ave.
Shreveport, LA 71103
318.698.2300
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WWW.LABLIND.COM

To: Older Blind Program
Documentation of Assistive technology and Low Vision Aids distributed to client.

Participant's Name: _____

INVOICE

Date Services Rendered:		Invoice Date:	
Quantity	Item Description	Unit Price	Total Price
		SUBTOTAL	
		TOTAL DUE FROM CONSUMER	

I confirm that I have received all the items as indicated on this document and agree to return listed items if and when the device or piece of equipment is no longer beneficial and/or needed by the user. I understand and agree that I am responsible for proper handling and use of the
device(s).

_____ _____
Client Signature **Date of Signature**

_____ _____
LVRC Employee Signature **Date of Signature**