Proof of Payment

Immigration Medical Services

Receipt Number:

Date of Payment:

Payer's Full Name:

Payer's Contact Number:

Payer's Email Address:

Service Description	Amount (USD)
Immigration Medical Examination	
Additional Services (if any)	
Total Paid	

Payment Method:

Authorized Signature:

Date of Issue:

Thank you for your payment.
This document serves as proof of payment for immigration medical services.