**Health Care Professional Invoice**

**HCP Name & address: Invoice to:**

**AtriCure BV**

AtriCure *Accounts Payable*

De Entrée II

De Entrée 260, 18th floor

1101 EE Amsterdam Z.O.

The Netherlands

**ACTIVITIES PERFORMED** *(check & fill-in corresponding activity):*

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Event: Hybrid AF Convergent Core Faculty Meeting

Date, Place: May 13/14 -2022

Frankfurt/ Germany

**EXPENSES**

|  |  |  |
| --- | --- | --- |
|  | Description of Reimbursable Expenses | Currency & Amount |
| Dates | *Please list your expenses below**(scanned detailed original receipts required)* |  |
| May 13-2022 |  |  |
|  |  |  |
|  |  |  |
| May 14-2022 |  |  |
|  |  |  |
|  |  |  |
| **TOTAL** | |  |

Name: *Atricure attendance: Pia Gremmel*

Date:

Signature:

**Bank details**

Country:

Name of bank:

Account Holder:

IBAN:

Swift Code:

Please submit this form via email to [physicianengagement@atricure.com](mailto:physicianengagement@atricure.com)