

Wisconsin Center for Nursing (WCN) REQUEST FOR PAYMENT INVOICE

Department of Workforce Development

State of Wisconsin

Supplier Name and Remittance Address*	Supplier Contact Name*
	Supplier Contact Phone Number*

Supplier Remittance Email *	Supplier ID*	Reporting Month/Year*

Invoice Date*	
Invoice Number or Description*	
Total Invoice Amount	
PO Number*	

Item/Description*	Amount*
	\$
	\$
	\$
	\$
	\$
	\$
	\$
	\$
	\$
	\$
	\$
	\$
	\$
	\$
	\$

All fields with a " * " are required in order to process an invoice

The submission of this report certifies that the expenditures identified here, claiming federal and state reimbursement, are true and correct in the amounts stated, have not been reimbursed previously, and represent actual and necessary costs of administering provisions of the contract.

Payment will be made 2-3 days after approval of the invoice by DET.

For other reports, updates, and other information visit <https://dwd.wisconsin.gov/comet/>
FIS-17881-E (R: 10/2025)

Instructions for Use:

1. The items that have asterisks MUST be filled in:
 - a. Supplier Name and Address (info is on Purchase Order)
 - b. Supplier Contact Name
 - c. Supplier Contact Phone Number
 - d. Supplier Remittance Email
 - e. Supplier ID (info is on Purchase Order)
 - f. Reporting Month/Year
 - g. Invoice Date
 - h. Invoice Number or Description (Use your own references for tracking)
 - i. PO Number (info is on Purchase Order)
 - j. Item/Description (info is on Purchase Order, titles must match exactly. DON'T use line numbers.)
 - k. Amount (negative amounts are allowed for lines, but not for total invoice amount)
2. If there are more than 13 lines to request submit an additional form.
3. When completed, you can send the request to the following email address:
Heather.Thompson@dwd.wisconsin.gov