INVOICE

License No: ___________________

Pharmaceutical Distributor Name

Address Line 1
City, State, Zip
Contact: (000) 000-0000

BILL TO:
Institution Name:
Address:
Drug License ID:
DETAILS:
Invoice #: ___________________
Date: ___________________
PO #: ___________________

Drug Name / Strength	Batch No.	Expiry	Qty (Bulk)	Unit Price	Total

Subtotal: $0.00
Tax/VAT: $0.00

GRAND TOTAL: $0.00

Storage Conditions: ____

Terms: Goods once sold will not be taken back. Subject to local jurisdiction.

Authorized Signatory