

# CLINICAL INVENTORY INVOICE

[Clinic Name]  
[Department / Unit]  
[Facility Address Line 1]  
[Phone / Email]

**Invoice #:** \_\_\_\_\_  
**Date:** \_\_\_\_\_  
**PO #:** \_\_\_\_\_  
**Supplier ID:** \_\_\_\_\_

---

**Vendor / Supplier:**

[Company Name]  
[Address]  
[Contact Name]

SKU / Catalog #	Item Description	Lot / Batch #	Exp. Date	Qty	Unit Price	Total

<b>Subtotal:</b>	\$ 0.00
<b>Tax / VAT:</b>	\$ 0.00
<b>Grand Total:</b>	<b>\$ 0.00</b>

**Notes / Handling Instructions:** \_\_\_\_\_

**Receiver Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Certified Clinical Inventory Record