

# INVOICE

Medical Supply & Inventory

**Invoice #:** \_\_\_\_\_

**Date:** \_\_\_\_\_

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**FROM:**

Institution Name  
Street Address  
City, State, Zip  
Phone / Email

**BILL TO:**

Client/Department Name  
Street Address  
City, State, Zip  
Attn: Name

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

Subtotal: \$ \_\_\_\_\_  
Tax: \$ \_\_\_\_\_  
Shipping/Handling: \$ \_\_\_\_\_  
**Balance Due: \$** \_\_\_\_\_

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**Notes / Special Handling:**

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Terms: Net 30. Please include invoice number with payment.