

PHARMACEUTICAL INVOICE

Pharmacy Name: _____

License No: _____

Invoice #: _____

Date: _____

Supplier / Consignor:

Name: _____

Address: _____

Contact: _____

Ship To / Consignee:

Name: _____

Address: _____

Facility ID: _____

NDC / Item Code	Description & Strength	Batch/Lot #	Expiry	Qty	Unit Price	Total
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

Subtotal: \$ _____

Tax: \$ _____

Grand Total: \$ _____

Notes: Controlled substances must be verified upon receipt. Report discrepancies within 24 hours.

Pharmacist Signature: _____

Receiver Signature: _____