

# INVOICE

**Wholesale Medicine Co.**  
123 Pharma Lane, Medical District  
City, State, Zip

Invoice #: \_\_\_\_\_  
Date: \_\_\_\_\_  
Due Date: \_\_\_\_\_

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**Bill To:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Ship To:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Item Description / Medicine Name	Batch No.	Expiry	Qty	Unit Price	Total

Item Description / Medicine Name	Batch No.	Expiry	Qty	Unit Price	Total

Subtotal: \$ \_\_\_\_\_

Tax: \$ \_\_\_\_\_

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**Grand Total: \$ \_\_\_\_\_**

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**Terms:** All medicine returns must be within 30 days and in original packaging.

**Authorized Signature:** \_\_\_\_\_