INVOICE

[Your Name/Agency Name]
[Medical Translation Certification No.]
[Street Address]
[City, State, Zip]
[Email/Phone]

Invoice #: [00000]
Date: [MM/DD/YYYY]
Due Date: [MM/DD/YYYY]

BILL TO:

[Client Name/Healthcare Facility]
[Department/Contact Person]
[Address]
[City, State, Zip]

PROJECT REF:

[Patient ID/Case Number]
[Language Pair]
[Service Type: e.g., Clinical Trial/SOP]

NOTICE: HIPAA/DATA PRIVACY COMPLIANT TRANSACTION

Description of Medical Translation Services	Unit Type	Quantity	Rate	Amount
[Document Title/Medical Report Name]	[Words/Hours]	0	$0.00	$0.00
[Medical Terminology Research/Validation]	[Flat Fee]	0	$0.00	$0.00

Description of Medical Translation Services	Unit Type	Quantity	Rate	Amount
[Urgent/Rush Delivery Surcharge]	[%]	0	$0.00	$0.00

Subtotal: $0.00
Tax: $0.00

Total Due: $0.00

Payment Instructions: [Bank Transfer / PayPal / Check Info]

Notes: All translations performed in accordance with ASTM F2575/ISO 17100 standards for medical translation quality assurance.