MEDICAL CENTER

Sterilization Services Department
123 Healthcare Blvd
Medical District

INVOICE

Date: [Date]
Invoice #: [00000]
Project ID: [ID-Number]

Billing To:

[Department Name]
[Contact Name]
[Building/Room Number]

Project Scope:

Sterilization of [Equipment/Facility Area]
Cycle Type: [Steam/EtO/Plasma]
Compliance Standard: [ISO/AAMI]

Description of Service / Items	Quantity	Unit Price	Total
Biological Indicators & Validation Testing	[Qty]	$0.00	$0.00
High-Level Disinfection (HLD) Processing	[Qty]	$0.00	$0.00
Instrument Decontamination & Packaging	[Qty]	$0.00	$0.00
Sterile Barrier Materials & Consumables	[Qty]	$0.00	$0.00

Subtotal: $0.00
Processing Fee: $0.00

TOTAL DUE: $0.00

Payment Terms: Net 30 Days. Please include Invoice Number with payment.

Certification: All processes performed in accordance with [Regulatory Body] standards for Medical Device Sterilization.