INVOICE

Medical Translation Services

INVOICE #
[0000]
DATE:
[Date]

SERVICE PROVIDER:
[Translator/Agency Name]
[Address Line 1]
[Email/Phone]
[Certification/License No.]

BILL TO:
[Client/Hospital Name]
[Department/Attention]
[Address Line 1]
[Contact Email]

PROJECT DETAILS:
Agreement Reference: [Contract ID / Date]

Description of Medical Records / Services	Units (Words/Hrs)	Rate	Amount
[e.g., Clinical Trial Protocol Translation]	[0,000]	$[0.00]	$[0.00]
[e.g., Patient Consent Forms - Localization]	[0,000]	$[0.00]	$[0.00]
[e.g., Medical Terminology Review/Proofreading]	[0.0]	$[0.00]	$[0.00]

Subtotal: $[0.00]

Tax ([0]%): $[0.00]

Total Amount Due: $[0.00]

PAYMENT INSTRUCTIONS:
Bank Name: [Name]

Account Number / IBAN: [Number]
SWIFT/BIC: [Code]
Terms: Due within [30] days of receipt.

Note: All medical translations are handled in compliance with HIPAA/GDPR confidentiality standards. Verification of medical accuracy has been performed as per the Service Agreement.