

# INVOICE

**[Healthcare Company Name]**  
[Street Address]  
[City, State, Zip]  
[Phone Number] | [Email/Website]

**Invoice #:** \_\_\_\_\_  
**Date:** \_\_\_\_\_  
**PO #:** \_\_\_\_\_

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**BILL TO**

[Customer/Facility Name]  
[Department/Contact]  
[Street Address]  
[City, State, Zip]

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**SHIP TO**

[Facility Name]  
[Loading Dock/Suite]  
[Street Address]  
[City, State, Zip]

Catalog #	Description of Equipment/Supplies	Qty	Unit Price	Total

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Subtotal: \$ \_\_\_\_\_  
Shipping & Handling: \$ \_\_\_\_\_  
Tax: \$ \_\_\_\_\_  
Balance Due: \$ \_\_\_\_\_

**Terms & Conditions:** Payment is due within [30] days. All medical equipment remains the property of [Company Name] until paid in full. Returns are subject to a [15]% restocking fee. Please include invoice number with your remittance.