

# HOSPITAL SUPPLY INVOICE

[Medical Company Name]  
[Street Address]  
[City, State, Zip]  
[Phone] | [Email]

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

**Bill To:**

[Hospital Name]  
[Department Name]  
[Address Line 1]  
[City, State, Zip]

**Ship To:**

[Receiving Dock/Floor]  
[Hospital Name]  
[Address Line 1]  
[City, State, Zip]

SKU/Ref #	Description of Medical Supplies	Qty	Unit Price	Total

SKU/Ref #	Description of Medical Supplies	Qty	Unit Price	Total

Subtotal: \$ \_\_\_\_\_  
Tax (\_\_\_%): \$ \_\_\_\_\_  
Shipping/Handling: \$ \_\_\_\_\_

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

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**Terms:** Net [30] Days. Please make checks payable to **[Company Name]**.

**Notes:** All medical supplies are inspected for quality compliance. Please report discrepancies within 48 hours of receipt.