# MEDICAL DEVICE INVOICE

**[Manufacturer Name]**
[Street Address]
[City, State, Zip Code]
[Phone Number] | [Email/Website]
FDA Establishment Reg #: [Number]

**Invoice #:** [000000]
**Date:** [MM/DD/YYYY]
**PO Number:** [Reference]

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**Bill To:**

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

**Ship To:**

[Facility Name]
[Attn: Receiving Department]
[Street Address]
[City, State, Zip Code]

| Item / Catalog # | UDI / Lot # | Description | Qty | Unit Price | Total |
|---|---|---|---|---|---|
| [SKU-123] | [Lot: 000] | [Medical Device Name / Specifications] | [0] | $0.00 | $0.00 |
| [SKU-456] | [Lot: 000] | [Consumables / Accessories] | [0] | $0.00 | $0.00 |

Subtotal: $0.00
Shipping & Handling: $0.00

Tax: $0.00
Amount Due (USD): $0.00

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*Compliance: All devices listed above are manufactured in accordance with ISO 13485 standards and applicable regulatory requirements.*

**Payment Terms:** Net 30. Please make checks payable to [Company Name].
**Wire Transfer:** Bank: [Name] | Account: [Number] | Routing: [Number]
**Notes:** Sterility guaranteed unless package is opened or damaged.