[Company Name]

Orthopedic Solutions & Surgical Supplies
[Address Line 1]
[City, State, Zip]
[Phone Number]

INVOICE

[Invoice Number]
Date: [Date]
PO Number: [PO #]

BILL TO

[Hospital/Clinic Name]
[Accounts Payable Dept]
[Address]
[Contact Email/Phone]

CASE REFERENCE

Patient ID: [ID/Ref Number]
Surgeon: [Name]
Procedure Date: [Date]
Facility: [Location]

Ref/Catalog #	Product Description	Lot/Serial #	Qty	Unit Price	Total
[Item #]	[Product Name/Size]	[Batch]	[Qty]	$0.00	$0.00

Ref/Catalog #	Product Description	Lot/Serial #	Qty	Unit Price	Total

Subtotal: $0.00
Tax: $0.00
Grand Total: $0.00

Terms: Net [30] Days. All sterile packaging must be intact for returns.

Certification: We hereby certify that these goods were produced in compliance with FDA regulatory requirements for orthopedic medical devices.