

INVOICE

Medical Rehabilitation Supplies Co.

Invoice #: _____

Date: _____

BILL TO:

Name: _____

Facility: _____

Address: _____

Phone: _____

SHIP TO:

Name: _____

Address: _____

City/State: _____

Postal Code: _____

Item Description	Model #	Qty	Unit Price	Total
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Item Description	Model #	Qty	Unit Price	Total
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Subtotal: \$ _____

Tax: \$ _____

Shipping: \$ _____

TOTAL: \$ _____

Payment Terms: Due within 30 days. Please make checks payable to Medical Rehabilitation Supplies Co.

Warranty: Equipment is covered under manufacturer warranty for 12 months from date of purchase.

Authorized Signature