[Medical Supply Company Name]

[Street Address]
[City, State, Zip]
Phone: [000-000-0000]
License #: [Wholesale License ID]

INVOICE

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

BILL TO:

[Facility/Hospital Name]
[Billing Address]
[City, State, Zip]
Attn: Accounts Payable

SHIP TO:

[Receiving Department]
[Shipping Address]
[City, State, Zip]
Attn: [Contact Name]

SKU / Catalog #	Description	Lot / Batch #	Exp. Date	Qty	Unit Price	Total
[Item Code]	[Medical Product Description]	[Lot #]	[YYYY-MM]	[0]	$0.00	$0.00

SKU / Catalog #	Description	Lot / Batch #	Exp. Date	Qty	Unit Price	Total

Subtotal: $0.00
Shipping & Handling: $0.00
Tax (if applicable): $0.00
Total Amount: $0.00

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

Notes: All medical supplies must be inspected upon delivery. Returns must be authorized within [X] days and include original lot numbers.