[PHARMABRAND NAME]
GLOBAL DISTRIBUTION DIVISION

INVOICE

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

FROM

[PharmaBrand Corp Headquarters]
[123 Pharmaceutical Way]
[Life Science Park, State, Zip]
Licence #: [DEA-0000000]

SHIP TO / BILL TO

[Recipient Facility/Pharmacy Name]
[456 Medical Blvd]
[City, State, Zip]
Facility ID: [FAC-0000]

NDC Number	Description / Brand Name	Lot / Exp	Qty	Unit Price	Total
[0000-0000-00]	Rx [Product Name / Strength / Form]	[LOT-00 / 00-00]	[0]	$[0.00]	$[0.00]
[0000-0000-00]	Rx [Product Name / Strength / Form]	[LOT-00 / 00-00]	[0]	$[0.00]	$[0.00]

Subtotal: $[0.00]
Tax / Handling: $[0.00]
Amount Due: $[0.00]

Notes: All controlled substances must be verified upon receipt. Please report discrepancies within 24 hours.

Terms: Payment due within [30] days. Make all checks payable to [PharmaBrand Corp].

Thank you for your partnership in healthcare.