[Healthcare Entity Name]

[Facility Address Line 1]
[Department/Pharmacy Division]
Phone: [000-000-0000]

INVOICE

Invoice #: [00000]
Date: [MM/DD/YYYY]
PO #: [00000]

VENDOR / SUPPLIER

[Supplier Name]
[Remittance Address]
[Contact Name]

SHIP TO

[Receiving Loading Dock]
[Attn: Central Supply]
[City, State, Zip]

SKU / NDC #	Description of Supplies / Medication	Qty	Unit	Price	Total
[0000-0000]	[Product Name / Specification]	[0]	[Box/Ea]	$[0.00]	$[0.00]
[0000-0000]	[Product Name / Specification]	[0]	[Box/Ea]	$[0.00]	$[0.00]

Subtotal: $[0.00]
Tax / Fees: $[0.00]
Shipping: $[0.00]

Total Balance Due: $[0.00]

Notes: FDA Compliance: All medical devices and pharmaceuticals listed above comply with [Relevant Regulation]. Items must be inspected upon receipt for cold-chain integrity where applicable.

Payment Terms: Net [30] Days. Please include invoice number on remittance.