SALES INVOICE

[Hospital Equipment Co. Name]
[Address Line 1]
[City, State, Zip]
[Phone Number] | [Email/Website]

Invoice #: _____
Date: _____
PO #: _____

Bill To:

[Customer/Hospital Name]
[Department/Attn]
[Address]
[City, State, Zip]

Ship To:

[Facility Name]
[Loading Dock/Room #]
[Address]
[City, State, Zip]

Model / SKU	Description of Equipment	Qty	Unit Price	Total

Subtotal: $0.00

Tax (___%): $0.00
Shipping: $0.00

Total Amount: $0.00

Terms & Conditions: Payment due within [X] days. Warranty information attached separately. All medical devices are subject to standard compliance regulations.

Authorized Signature: _____