INVOICE

[Medical Furniture Company Name]
[Street Address]
[City, State, Zip Code]
[Phone Number / Email]

Invoice #: _____
Date: _____
Purchase Order #: _____

BILL TO

[Client / Hospital Name]
[Department]
[Billing Address]
[City, State, Zip Code]

SHIP TO

[Facility Name]
[Loading Dock / Suite #]
[Shipping Address]
[City, State, Zip Code]

Model/SKU	Description (Medical Furniture)	Qty	Unit Price	Total

Subtotal: $0.00
Shipping/Installation: $0.00
Tax: $0.00
Amount Due: $0.00

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

Notes: All medical furniture includes standard manufacturer warranty unless otherwise specified. Installation services are subject to site readiness.