INVOICE

[Your Name/Agency Name]
[Medical Certification Number]
[Street Address]
[City, State, Zip]
[Email/Phone]

INVOICE # [0000]
DATE: [Date]
DUE DATE: [Date]

BILL TO:

[Client Name/Hospital/Clinic]
[Department/Attn:]
[Street Address]
[City, State, Zip]

PROJECT REF:

[Patient ID/Case Number]
[Language Pair: Source to Target]

Description of Services	Unit Type	Quantity	Rate	Amount
[Document Type: e.g., Pathology Report]	Words	[0,000]	$[0.00]	$[0.00]
[Document Type: e.g., Clinical Trial Protocol]	Words	[0,000]	$[0.00]	$[0.00]
[Medical Review / Editing]	Hours	[0.0]	$[0.00]	$[0.00]

Description of Services	Unit Type	Quantity	Rate	Amount
[Urgency/Rush Fee]	Flat	1	$[0.00]	$[0.00]

Subtotal: $[0.00]

Tax (if applicable): $[0.00]

TOTAL DUE: $[0.00]

PAYMENT INSTRUCTIONS:
Bank Name: [Name] | SWIFT/IBAN: [Code] | PayPal: [Email]

Note: This medical translation was performed in accordance with ISO 17100 standards or relevant regulatory requirements.