CREDIT NOTE

[Supplier Name]
[Healthcare Supply Division]
[Address Line 1]
[City, State, Zip]
[Tax ID/VAT Number]

Credit Note #: _____
Date: _____
Original Invoice #: _____
Account #: _____

BILL TO: (HEALTHCARE PROVIDER)
[Facility Name]
[Department Name]
[Address Line 1]
[City, State, Zip]

REASON FOR CREDIT
[ ] Damaged Goods / Medical Grade Failure
[ ] Short Shipment
[ ] Incorrect Pricing/Contract Tier
[ ] Product Recall

Product/SKU	Description	Quantity	Unit Price	Tax %	Total Credit

Subtotal: $ _____
Tax Amount: $ _____
Total Credit Amount: $ _____

Note: This credit will be applied to your outstanding balance. For questions regarding medical supply returns or clinical documentation requirements, please contact our billing department at [Phone/Email].

Authorized Signature: _____ Date: _____