Medical Translation Invoice

[Specialist Name/Agency]
[Certification Credentials]
[Email/Phone]

Invoice #: [000]
Date: [Date]
Due Date: [Date]

BILL TO:

[Client Name/Hospital/CRO]
[Department]
[Address]

PROJECT DETAILS:

PO Number: [Reference]
Source Language: [Language]
Target Language: [Language]

Description (Document Type/Subject Matter)	Quantity (Words/Hours)	Rate	Amount
[e.g., Clinical Trial Protocol / Informed Consent Form]	[0,000]	$[0.00]	$[0.00]
[e.g., Medical Records / Discharge Summary]	[0,000]	$[0.00]	$[0.00]
[e.g., Certification of Translation Accuracy]	[1]	$[0.00]	$[0.00]

Subtotal: $[0.00]
Tax/VAT: $[0.00]

Total Amount: $[0.00]

PAYMENT INSTRUCTIONS:

Bank Transfer (IBAN/SWIFT): [Details]

PayPal/Digital Payment: [Details]

Thank you for your business. Confidentiality maintained according to HIPAA/GDPR standards.