

PROFORMA INVOICE

[Manufacturer Name]

[Street Address]

[City, State, Zip]

[Country]

[Tax ID/VAT Number]

[FDA Registration / ISO Number]

Date: _____

Invoice #: _____

PO Reference: _____

Payment Terms: _____

Bill To:

[Customer Name]

[Address Line 1]

[Address Line 2]

[Country]

[Contact Phone]

Ship To / Consignee:

[Hospital/Distributor Name]

[Delivery Address]

[Delivery City, Country]

[Notify Party Contact]

Shipping Information:

Method: [Air/Sea/Express]

Incoterms: [e.g. FCA, CIF, EXW]

Port of Loading: _____

Country of Origin: _____

Banking Details:

Bank: [Bank Name]

SWIFT/BIC: _____

IBAN/Account: _____

Model / Part #	Description of Medical Device (incl. GMDN/GTIN)	Qty	Unit	Unit Price	Total

Subtotal: [Currency] 0.00
Shipping & Handling: 0.00
Insurance: 0.00

TOTAL AMOUNT: [Currency] 0.00

Declaration & Regulatory Notes:

- 1. Goods are intended for medical use as specified in the technical documentation.
- 2. Sterility and shelf-life are guaranteed as per the attached Certificate of Analysis/Conformance.
- 3. This is a Proforma Invoice only; a Commercial Invoice will be issued upon shipment.

Regulatory Compliance: All devices listed conform to [MDR 2017/745 / 21 CFR 820] standards. Estimated Lead Time: [X] Weeks from receipt of payment.

Authorized Signature

Company Stamp