MEDICAL LINEN INVOICE

Linen Service Provider Name
123 Sterilization Way
City, State, Zip
Phone: (555) 000-0000

Invoice #: _____
Date: _____
Service Period: _____

BILL TO:

Facility Name:
Attention:
Address:
City, State, Zip:

DELIVERY / ROUTE INFO:

Route ID:
Driver Name:
Delivery Date:

Item Description (Linen Type)	Pickup (Soil)	Delivery (Clean)	Unit Price	Total Price
Bed Sheets (Twin/Hospital)			$	$
Pillowcases (Standard/Antimicrobial)			$	$
Patient Gowns (Standard/XL)			$	$
Bath Towels / Washcloths			$	$

Item Description (Linen Type)	Pickup (Soil)	Delivery (Clean)	Unit Price	Total Price
Surgical Scrubs (Sets)			$	$
Hazardous Waste Bags / Fluid Barriers			$	$
		Replacement Fee (Lost/Damaged)		$

Subtotal: $ _____
Sanitization/Fuel Surcharge: $ _____
Tax: $ _____

Amount Due: $ _____

Terms: Payment due within 30 days. All linens are processed according to CDC healthcare laundry guidelines.

Customer Signature: _____ Date: _____