

[Medical Company Name]

[Street Address]
[City, State, Zip]
Phone: [000-000-0000]
Tax ID: [00-0000000]

INVOICE

No: [Invoice #]
Date: [MM/DD/YYYY]
PO Number: [PO #]

BILL TO

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

SHIP TO

[Shipping Destination]
[Facility Name]
[Loading Dock/Suite]
[Street Address]
[City, State, Zip]

Ref/Model #	Description	Qty	Unit Price	Total
[Model-001]	[Medical Equipment Name] - [Serial #]	[0]	\$0.00	\$0.00
[Model-002]	[Accessory/Component]	[0]	\$0.00	\$0.00

Ref/Model #	Description	Qty	Unit Price	Total
[Service]	Installation & Calibration Service	[0]	\$0.00	\$0.00

Subtotal: \$0.00

Shipping/Handling: \$0.00

Tax: \$0.00

Total Amount: \$0.00

Payment Terms: [Net 30 Days]. Please make checks payable to [Medical Company Name].

Regulatory Notice: This medical device is sold subject to the manufacturer's warranty and FDA/CE compliance standards. Sterile items are non-returnable if the seal is broken.