

BIOMEDICAL DEVICE INVOICE

[Organization Name]
[Address Line 1]
[Address Line 2]

Invoice #: [000000]
Date: [Date]
PO #: [PO Number]

VENDOR / SELLER

[Name]
[Company Name]
[Contact Details]
[Tax ID/Registration]

SHIP TO / BILLING

[Facility/Hospital Name]
[Department]
[Delivery Address]
[Contact Person]

Description / Model #	Serial / Lot #	Qty	Unit Price	Total
[Device Name / Technical Specs]	[SN-0000]	[0]	[\$[0.00]]	[\$[0.00]]
[Accessories/Software Licenses]	[N/A]	[0]	[\$[0.00]]	[\$[0.00]]
[Extended Warranty / Service Contract]	[Term]	[0]	[\$[0.00]]	[\$[0.00]]

Subtotal: \$[0.00]
Shipping & Handling: \$[0.00]
Tax (VAT/GST): \$[0.00]
Amount Due: \$[0.00]

REGULATORY COMPLIANCE & NOTES

FDA/CE Certification Status: [Status]

Installation Requirements: [Included/Excluded]

Payment Terms: [Net 30/Net 60]

Wiring Instructions: [Bank Name / Account Details]