PURCHASE INVOICE

[Clinic Name]
[Street Address]
[City, State, Zip]
[Phone Number]

Invoice #: _____

Date: _____

PO #: _____

VENDOR / SUPPLIER

[Supplier Name]
[Contact Name]
[Address Line 1]
[Address Line 2]

SHIP TO

[Department/Attention]
[Facility Name]
[Delivery Address]
[Delivery Instructions]

Catalog #	Description of Supplies	Qty	Unit Price	Tax	Total

Subtotal: $ _____
Shipping & Handling: $ _____
Tax Amount: $ _____
Amount Due: $ _____

PAYMENT TERMS & NOTES

Net 30. Please include invoice number on all remittances. For clinical grade verification, refer to Batch/Lot certificates where applicable.

Authorized Signature: _____ *Date:* _____