

DIAGNOSTIC SYSTEM ORDER

Provider: [Company Name]
[Address Line 1]
[Address Line 2]

Invoice #: _____
Date: _____

Bill To:
[Client Name]
[Department/Clinic]
[Address]

System Details:
Model: _____
ID: _____

Description	Qty	Unit Price	Total
Hardware/Module Components	_____	\$ _____	\$ _____
System Software License	_____	\$ _____	\$ _____
Calibration & Setup	_____	\$ _____	\$ _____
Maintenance Agreement	_____	\$ _____	\$ _____

Subtotal: \$ _____
Tax: \$ _____
Grand Total: \$ _____

Notes: All diagnostic systems include a standard 12-month manufacturer warranty unless otherwise specified. Payment is due within 30 days of invoice date.