HOSPITAL INVOICE

[Hospital Name]
[Department Name]
[Street Address]
[City, State, Zip]

Invoice #: _____

Date: _____

P.O. #: _____

VENDOR / BILL FROM:

[Supplier Name]
[Contact Name]
[Address]
[Phone/Email]

SHIP TO:

[Hospital Receiving Dock]
[Attn: Name/Department]
[Address]
[Phone]

SKU/Item #	Description	Quantity	Unit Price	Total

SKU/Item #	Description	Quantity	Unit Price	Total

Subtotal: $ _____
Tax: $ _____
Shipping: $ _____
Total Due: $ _____

Notes / Terms: Net 30 payment terms. Please include Invoice Number on all remittances.

Authorized Signature: _____ Date: _____