

INVOICE

[Medical Supply Co. Name]
[Address Line 1]
[City, State, Zip]
[Phone Number] | [Email]

Invoice #: [00000]
Date: [MM/DD/YYYY]
Purchase Order: [PO-000]

Bill To:

[Facility/Hospital Name]
[Department]
[Billing Address]
[Contact Name]

Ship To:

[Facility/Hospital Name]
[Loading Dock/Suite]
[Shipping Address]
[Contact Phone]

SKU/Model	Description	Qty	Unit Price	Total
[SKU-1]	[Medical Equipment Item Description]	[0]	[\$[0.00]]	[\$[0.00]]
[SKU-2]	[Medical Consumables/Accessories]	[0]	[\$[0.00]]	[\$[0.00]]

Subtotal: \$[0.00]
Tax (0%): \$[0.00]
Shipping/Handling: \$[0.00]

Grand Total: \$[0.00]

Payment Terms: [Net 30/Due on Receipt]

Notes: All medical equipment includes a [X]-year manufacturer warranty unless otherwise specified. Sterility guaranteed only if packaging is unopened.

Thank you for your business.