

[Physician/Practice Name]
[Street Address]
[City, State, Zip]
[Phone Number]

PROCUREMENT INVOICE

VENDOR INFORMATION

[Vendor Name]
[Vendor Address]
[Contact Person]

REFERENCE

Invoice #: [_____]]
Date: [_____]]
PO #: [_____]]
Account #: [_____]]

SKU / Code	Description (Medical Supplies/Equipment)	Qty	Unit Price	Total

Subtotal: \$0.00
Tax/Shipping: \$0.00
Total Due: \$0.00

Authorized Signature: _____ Date: _____

Please include the Invoice Number on all payments and correspondence.