PROFORMA INVOICE

Healthcare Facility Equipment

Invoice #: [000000]

Date: [YYYY-MM-DD]

Expiry Date: [YYYY-MM-DD]

SELLER / PROVIDER [Medical Supply Company Name]
[Street Address]
[City, State, Zip]
[Tax ID / VAT Number]
BILL TO / SHIP TO [Healthcare Facility Name]
[Department/Contact Person]
[Street Address]
[City, State, Zip]

Item Description	Model/SKU	Qty	Unit Price	Amount
[Equipment Name]	[Ref #]	[0]	0.00	0.00
[Equipment Name]	[Ref #]	[0]	0.00	0.00
[Consumables/Accessories]	[Ref #]	[0]	0.00	0.00

Subtotal: $0.00
Tax/VAT (%): $0.00
Shipping & Handling: $0.00

Grand Total: $0.00

Payment Terms: [e.g., 50% Advance, 50% upon delivery]

Bank Details: [Bank Name] | **SWIFT:** [Code] | **Account:** [Number]

Notes: Warranty: [Period]. Lead time: [Weeks] from receipt of payment.