PROFORMA INVOICE

[Company Name]
[Street Address]
[City, State, Zip]
[Tax ID/VAT Number]

Date: _____
Invoice #: _____
Expiry Date: _____

BILL TO:

_____
_____
_____
Phone: _____

SHIP TO:

_____
_____
_____
Contact: _____

Model / SKU	Device Description	Qty	Unit Price	Total

Subtotal: $ _____
Tax / VAT: $ _____
Shipping: $ _____

GRAND TOTAL: $ _____

Payment Terms: _____
Shipping Method: _____
Country of Origin: _____

Notes: All medical devices listed above comply with [Regulatory Standard, e.g., ISO 13485 / FDA]. This is not a demand for payment, but a preliminary invoice for customs or financing purposes.

Authorized Signature: _____ Date: _____