PROFORMA INVOICE

[Medical Company Name]
[Street Address]
[City, State, Zip]
[License/Tax ID]

Date: [Date]
Invoice #: [Reference Number]
Expiry: [Valid Until Date]

BILL TO / CONSIGNEE

[Institution/Clinic Name]
[Contact Person]
[Address Line 1]
[Phone/Email]

SHIPPING DETAILS

Method: [Air/Sea/Ground]
Payment Terms: [e.g., Net 30]
Currency: [USD/EUR/GBP]
Est. Delivery: [Lead Time]

Catalog #	Description of Goods	Qty	Unit	Unit Price	Amount
[SKU-001]	[Product Description/Specification]	[0]	[Box]	0.00	0.00
[SKU-002]	[Product Description/Specification]	[0]	[Each]	0.00	0.00
[SKU-003]	[Product Description/Specification]	[0]	[Pack]	0.00	0.00

Subtotal: 0.00

Shipping/Handling: 0.00
Tax/VAT ([%]): 0.00
Total: 0.00

BANKING & PAYMENT INSTRUCTIONS

Bank: [Bank Name] | SWIFT: [Code] | Account: [Number] | IBAN: [Number]

Note: All medical supplies are subject to quality assurance protocols. Sterility guaranteed only if packaging is unopened and undamaged. Goods remain the property of [Company Name] until full payment is received.