PROFORMA INVOICE

[Medical Company Name]
[Street Address]
[City, State, Zip]
[Phone / Email]

BILL TO:
[Customer Name/Hospital]
[Department]
[Address]
[Contact Number]
Proforma No: [Number]
Date: [DD/MM/YYYY]
Expiry Date: [DD/MM/YYYY]
Reference: [PO/Quote No]

Item Description	Model/REF	Qty	Unit Price	Total
Ventilator System, Invasive/Non-Invasive	[Model No]	0	$0.00	$0.00
Oxygen Concentrator (High Flow)	[Model No]	0	$0.00	$0.00
CPAP/BiPAP Unit	[Model No]	0	$0.00	$0.00
Replacement HEPA Filters (Pack)	[Part No]	0	$0.00	$0.00

Subtotal: $0.00
Shipping/Freight: $0.00
Tax: $0.00

TOTAL: $0.00

Terms & Conditions:

- Payment Terms: [e.g., 50% Advance, 50% before shipment]
- Estimated Lead Time: [Number] weeks
- Shipping Terms: [Incoterms e.g. EXW/FOB]
- Banking Details: [Bank Name / SWIFT / Account No]

Authorized Signature: ____________________________ Date: _______________