

PROFORMA INVOICE

[Company Name]
[Medical License No.]
[Address Line 1]
[Email/Phone]

Invoice No: _____
Date: _____
Expiry Date: _____

BILL TO / CONSIGNEE

[Client Name / Hospital]
[Department]
[Address]
[Tax ID / VAT No.]

SHIPMENT DETAILS

Port of Loading: _____
Port of Discharge: _____
Mode of Shipment: [Air / Sea / Courier]
Payment Terms: _____

Item Code	Description of Surgical Instruments	Grade/Material	Qty	Unit Price	Total

Subtotal: 0.00
Shipping/Freight: 0.00

Tax/VAT: 0.00

Total Amount: [Currency] 0.00

Banking Instructions:

Bank Name: _____

SWIFT/BIC: _____

IBAN/Account: _____

Authorized Signature & Stamp

STAMP

Note: All instruments are manufactured according to [ISO/CE] standards. Sterility guaranteed only if packaging is intact.