EQUIPMENT DONATION INVOICE

Invoice #: _____
Date: _____

DONOR INFORMATION

Name/Organization: _____
Address: _____
City, State, Zip: _____
Contact Email: _____

RECIPIENT INFORMATION (ER FACILITY)

Facility Name: _____
Department: Emergency Room / Trauma Unit
Address: _____
Tax ID (EIN): _____

Equipment Description & Model #	Condition	Qty	Fair Market Value (Unit)	Total Value

Subtotal Value: $ _____
Shipping/Handling (Donated): $ _____

Total Donation Value: $ _____

NOTES / WARRANTY INFORMATION

Authorized Donor Signature: _____

Date: _____

Receiving Officer Signature: _____

Date: _____

Thank you for your generous contribution to emergency medical services.