GIFT INVOICE

Date: ________________
Invoice #: ___________

Donor / Provider:
[Organization Name]
[Street Address]
[City, State, Zip]
[Phone/Email]
Recipient / Facility:
[Contact Name]
[Healthcare Facility Name]
[Shipping Address]
[City, State, Zip]

Equipment Description	Model/Serial #	Qty	Condition

Gift Message:

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Note: This is a gift invoice. No payment is required. The equipment listed above is provided for healthcare support purposes. Please retain this document for your inventory and asset management records.

Authorized Signature: _______________________ Date: ____________