

# DONATION INVOICE

Tax ID / EIN: \_\_\_\_\_

Invoice #: \_\_\_\_\_

Date: \_\_\_\_\_

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## DONOR INFORMATION

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Organization: \_\_\_\_\_

Address: \_\_\_\_\_

Contact: \_\_\_\_\_

Phone: \_\_\_\_\_

## RECIPIENT CLINIC

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Clinic Name: \_\_\_\_\_

Department: \_\_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_

Device Description & Serial Number	Condition	Qty	Estimated FMV*
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**Total Estimated Donation Value: \$** \_\_\_\_\_

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**Authorized Donor Signature**

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**Recipient Acknowledgment Signature**

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\*FMV: Fair Market Value. The donor acknowledges that no goods or services were provided in exchange for this donation. Please consult a tax professional regarding the deductibility of laboratory equipment.