

DONATION INVOICE

Imaging System Contribution

Invoice #

Date

DONOR INFORMATION

Name:

Organization:

Address:

Email/Phone:

RECIPIENT CLINIC

Clinic Name:

Department:

Facility ID:

Tax ID/EIN:

Imaging Equipment Description	Model/Serial #	Condition	Fair Market Value
----------------------------------	-------------------	-----------	----------------------

TOTAL DONATION VALUE \$

NOTES / WARRANTY INFORMATION

Authorized Donor Signature
Clinic Representative Signature

This document acknowledges the receipt of the listed medical imaging equipment as a charitable donation.

No goods or services were provided in exchange for this contribution.