

DONATION INVOICE

Medical Tool Contribution

Date: _____
Invoice #: _____

DONOR INFORMATION

[Organization/Individual Name]

[Address Line 1]

[City, State, Zip]

[Phone/Email]

RECIPIENT INSTITUTION

[Medical Facility/NGO Name]

[Department/Unit]

[Address Line 1]

[Tax ID/Charity Reg #]

Description of Medical Tool	Model/Serial #	Condition	Qty	Est. Value
[Item Name]	[Reference No.]	[New/Used/Refurbished]	0	\$0.00

Total Appraised Value: \$ _____

COMPLIANCE & WARRANTY NOTES

Sterilization Status: Certified Requires Processing

Documentation Included: Manuals Maintenance Logs Calibration Certs

Authorized Donor Signature
Receiving Officer Signature

This document serves as an acknowledgment of non-monetary donation for medical use.