

# DONATION INVOICE

**Institution:** [Medical Research Organization Name]

[Street Address, City, State, Zip]

Tax ID / EIN: [00-0000000]

**Invoice #:** [0000]

**Date:** [MM/DD/YYYY]

---

## Donor Information:

[Donor Name / Company]

[Address]

[Email/Phone]

## Research Project Reference:

[Project Title or Grant ID]

Lead Researcher: [Name]

Description	Amount
Charitable Contribution for Medical Research Funding	\$ 0.00
Specific Equipment/Lab Resource Allocation (Optional)	\$ 0.00

---

Description	Amount
<b>Total Contribution:</b>	<b>\$ 0.00</b>

---

**Payment Instructions:**

Checks payable to: [Organization Name]

Wire Transfer: [Bank Name] | Account: [Number] | Routing: [Number]

---

*\* This organization is a registered 501(c)(3) non-profit. No goods or services were provided in exchange for this contribution. Please retain this invoice for your tax records.*

Thank you for supporting medical advancement.