INVOICE

WHITE GLOVE SERVICE

[Logistics Company Name]
[Street Address]
[City, State, Zip]
[Phone Number]

Invoice #: [00000]
Date: [MM/DD/YYYY]
Job Reference: [REF-ID]

BILLING DETAILS

[Client Name]
[Billing Address]
[City, State, Zip]

SERVICE LOCATION

[Consignee Name]
[Delivery Address]
[City, State, Zip]

Service Description	Quantity	Rate	Amount
White Glove Delivery Inside placement, room of choice, debris removal	[Qty]	$[0.00]	$[0.00]
Multi-Man Team [Number] person specialized crew	[Qty]	$[0.00]	$[0.00]
Specialized Packing/Crating	[Qty]	$[0.00]	$[0.00]
Fuel Surcharge / Accessorials	1	$[0.00]	$[0.00]

Subtotal: $[0.00]
Tax: $[0.00]
Total Amount Due: $[0.00]

NOTES / HANDLING INSTRUCTIONS

[Insert specific handling notes, e.g., Certificate of Insurance requirements or stairs/elevator access.]

PAYMENT TERMS

Net [30] Days. Please make checks payable to [Company Name].

Thank you for choosing our White Glove Premium Logistics services. All claims must be reported within 24 hours of delivery.