INVOICE

Medical Translation Services

Invoice #: _____
Date: _____

SERVICE PROVIDER

[Name/Organization]
[Address Line 1]
[Address Line 2]
[Email/Phone]

BILL TO

[Client Name/Clinic]
[Project Manager]
[Address Line 1]
[Tax ID/VAT if applicable]

Medical Document / Project Description	Source/Target Language	Quantity (Words/Hours)	Rate	Amount
[e.g., Clinical Trial Protocol]	[From] > [To]	_____	_____	_____
[e.g., Patient Informed Consent Form]	[From] > [To]	_____	_____	_____
[e.g., Medical Records Summary]	[From] > [To]	_____	_____	_____

Subtotal: $_____
Tax/VAT: $_____

Total Due: $_____

PAYMENT INSTRUCTIONS

Bank Name: _____
SWIFT/BIC: _____
Account Number/IBAN: _____

Certification: I hereby certify that the translations provided are accurate and reflect the medical terminology of the source documents.