MEDICAL ELECTRONIC REPAIR

Service & Calibration Department

INVOICE #: _____
DATE: _____

SERVICE PROVIDER

[Company Name]
[Street Address]
[City, State, Zip]
[Phone / Email]

BILL TO / FACILITY

[Client Name/Hospital]
[Department]
[Address]
[Contact Person]

EQUIPMENT DETAILS

Device: _____
Manufacturer: _____
Model: _____
Serial No: _____
Asset ID: _____
Warranty: [ ] Yes [ ] No

LABOR & SERVICES

Description of Service / Repair Action	Hours	Rate	Total
Initial Diagnostic & Safety Testing			
Component Repair / Replacement Labor			
NIST Traceable Calibration			

PARTS & MATERIALS

Part Number	Description	Qty	Unit Price	Total

Labor Total: $_____
Parts Total: $_____
Tax: $_____
BALANCE DUE: $_____

TECHNICIAN NOTES & CERTIFICATION

All repairs performed in accordance with manufacturer specifications and ISO 13485 standards. Electrical safety testing (NFPA 99/AAMI) completed where applicable.

Technician Signature: _____ Date: _____