[Service Provider Name]
Biomedical Engineering Dept/Clinic
[Street Address]
[City, State, Zip]
[License/Certification #]

REPAIR INVOICE

Date: _____
Invoice #: _____

HOSPITAL / CLIENT INFORMATION

[Facility Name]
[Department/Ward]
[Contact Person]
[Phone Number]

WORK ORDER DETAILS

Work Order #: _____
Date of Service: _____
Service Type: [ ] Preventive [ ] Corrective
Technician: _____

EQUIPMENT DETAILS

Device: _____
Manufacturer: _____
Model: _____
Serial No: _____
Asset Tag: _____
Location: _____

Description of Services / Parts Used	Qty/Hrs	Rate	Amount
Labor: Diagnostic & Troubleshooting			
Labor: Repair & Calibration			

Description of Services / Parts Used	Qty/Hrs	Rate	Amount
[Part Number/Name]			
[Part Number/Name]			
Travel / Shipping			

Subtotal:	$0.00
Tax:	$0.00
TOTAL:	$0.00

TECHNICIAN FINDINGS & SAFETY CHECKS

Summary: _____

[ ] Electrical Safety Test Passed (IEC 62353 / NFPA 99)
[ ] Performance Verification Passed

Technician Signature: _____
Client Approval Signature: _____

Warranty on parts and labor: [X] Days. Equipment certified for clinical use as of date above.