

MAINTENANCE INVOICE

Service ID: _____

Date: _____

Service Provider

[Company Name]

[Street Address]

[City, State, Zip]

[Phone/Email]

CLIENT / HOSPITAL INFORMATION

Facility: _____

Department: _____

Contact: _____

EQUIPMENT DETAILS

Model/Type: _____

Serial Number: _____

Asset ID: _____

Service Description (Parts & Labor)	Qty/Hrs	Rate	Amount
Preventative Maintenance / Inspection			
Leak Test & Channel Cleaning			
Replacement Parts (Valves, O-rings, etc)			
Minor/Major Repair Labor			

Subtotal: \$ _____

Tax: \$ _____
TOTAL DUE: \$ _____

TECHNICIAN NOTES & COMPLIANCE STATEMENT

Payment Terms: Net 30 Days. Please make checks payable to the service provider listed above.

Certified maintenance performed according to manufacturer specifications.