INVOICE

Service Provider: [Bio-Med Company Name]
[Address Line 1]
[City, State, Zip]

Invoice #: ___________
Date: ___________
Due Date: ___________

Bill To:
[Hospital/Clinic Name]
[Department Name]
[Attn: Contact Person]
[Full Address]
Service Location:
[Ward/Room Number]
[Facility Unit]
Contract #: ___________

Equipment ID / Serial	Description of Service (PM/Repair)	Hours/Qty	Rate	Amount

Subtotal: $0.00
Tax/VAT: $0.00

Total Due: $0.00

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

Maintenance Notes: All equipment tested according to [AAMI/Manufacturer] standards. Calibration certificates attached where applicable.