

SERVICE INVOICE

Medical Imaging Solutions Ltd.
Technical Engineering Department

Invoice #: _____
Date: _____
PO #: _____

CLIENT INFORMATION

Institution Name: _____
Department: _____
Address: _____

EQUIPMENT IDENTIFICATION

Modality: (MRI / CT / PET / X-Ray)
Manufacturer: _____
Model / Serial: _____
System ID: _____

Service Description (Parts & Labor)	Part / Code	Qty / Hrs	Rate	Amount

Subtotal: \$0.00
Tax / VAT: \$0.00
Shipping (Parts): \$0.00

Total Amount: \$0.00

TECHNICAL NOTES & COMPLIANCE

Compliance Testing Performed: Yes No

Calibration Standards Used: _____

Payment Terms: Net 30. Certified medical technicians performed all listed services according to manufacturer specifications.

Technician Signature: _____

Client Authorization: _____