MEDICAL CALIBRATIONS LTD.

[Street Address]
[City, State, Zip]
License: #000-000-000

INVOICE

Date: [Date]
Invoice #: [0000]
PO #: [0000]

CLIENT INFORMATION

[Hospital/Clinic Name]
[Department Name]
[Attn: Contact Name]
[Street Address]

CALIBRATION DETAILS

Lab Tech: [Name]
NIST Traceability: [Ref Number]
Environment: [Temp/Humidity]
Standards Used: [Asset ID]

** All calibrations performed in accordance with ISO/IEC 17025:2017 and ANSI/NCSL Z540.3-2006.*

Device Description	Model / Serial No.	Last Cal	Service Type	Price
[Device Name]	[M:00 / S:00]	[Date]	Annual Calibration	$0.00
[Device Name]	[M:00 / S:00]	[Date]	Diagnostic & Repair	$0.00

Subtotal: $0.00
Certification Fees: $0.00
TOTAL DUE: $0.00

TERMS & NOTES

Payment due within [30] days. Calibration certificates for the above items are attached/enclosed. Results relate only to the items calibrated at the time of service.