

SERVICE INVOICE

[Company Name]
[Address Line 1]
[City, State, Zip]
[Phone / Email]

Invoice #: _____
Date: _____
PO #: _____

CUSTOMER / FACILITY

[Contact Name]
[Hospital/Clinic Name]
[Address]
[City, State, Zip]

EQUIPMENT DETAILS

Laser Model: _____

Serial Number: _____

Service Type: Preventative Maintenance / Repair

Description of Service / Parts	Qty/Hrs	Unit Price	Total
Calibration & Safety Inspection			
Optical Alignment & Power Verification			
Replacement Part: [Item Name]			
Labor Fee			
Travel / Shipping			

Subtotal: \$ _____

Tax: \$ _____

Total Amount Due: \$ _____

Technician Signature

Facility Representative Signature

Notes: All maintenance performed according to manufacturer specifications. Biomedical safety test results attached. Payment is due within [Number] days. Thank you for your business.