

Company: _____

Name: _____

Street Address: _____

City, State: _____

ZIP Code: _____

E-mail: _____

Phone: _____

PHARMACY INVOICE

Invoice # _____

Date: _____

Client / Customer

Name: _____

Street Address: _____

City, State: _____

ZIP Code: _____

PRODUCTS (MATERIALS)

Description	Quantity	\$ / Unit	Amount
PRODUCTS			

LABOR

Description	Hours	\$ / Hour	Amount
LABOR			

Comments or Special Instructions:

SUBTOTAL	
DISCOUNT	
TAX	
TOTAL	

Payment is due within ____ days.

Thank you for your business!



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FREE ONLINE INVOICE