

# INVOICE

## Medical Facility Cleaning

Date: \_\_\_\_\_  
Invoice #: \_\_\_\_\_

### Billed To:

Facility Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State ZIP: \_\_\_\_\_  
Contact: \_\_\_\_\_

### Issued By (Cleaners):

Company Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City, State ZIP: \_\_\_\_\_  
Contact: \_\_\_\_\_

### Service Details

Description of Cleaning	Date	Qty	Unit Price	Total
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Subtotal	_____
Tax	_____
Total Due	_____

### Payment Notes

Payment Due By: \_\_\_\_\_  
Method of Payment: \_\_\_\_\_  
Additional Notes:  
\_\_\_\_\_  
\_\_\_\_\_