Pharmacy Name

Address Line 1, Address Line 2, City, State, ZIP
Phone: _____ | Email: _____
GSTIN: _____

Retail Sales Invoice

Customer Name: _____
Address: _____
Contact No: _____
Invoice No: _____
Date: ____ / ____ / _____
Doctor's Name: _____

S. No.	Medicine/Item Name	Batch No.	Expiry	HSN	Quantity	MRP	Rate	Discount	Amount
1									
2									
3									

Total Qty: _____

Subtotal: _____

Discount: _____

GST (%) : _____

Grand Total: _____

Amount in Words: _____

Thank you for your purchase!
This is a computer-generated invoice.

Authorized Signature