Supplier Name: _____ **Supplier Address:** _____ _____ **Contact:** _____

Supplier Invoice

Invoice No: _____ **Date:** ____ / ____ / _____ **Pharmacy Name:** _____
Pharmacy Address: _____

#	Medicine Name	Batch No.	Expiry Date	Qty	Unit Price	Discount	Tax (%)	Total
1	_____	_____	____/____	____	_____	_____	_____	_____
2	_____	_____	____/____	____	_____	_____	_____	_____
3	_____	_____	____/____	____	_____	_____	_____	_____

Subtotal _____

Total Discount _____

Total Tax _____

Grand Total _____

Notes:
_____

_____

Supplier's Signature

_____

Receiver's Signature