LOGO

PURCHASE ORDER

Medical Supplies

PO Number:	N 000000
Date:	DD/MM/YYYY

Hospital / Clinic:	Hospital / Clinic	
Department:	Department	
Contact Person:	Full Name	
Phone / Email:	(999)999-9999	user_name@email.com
Billing Address:	Billing Address	

Vendor / Supplier:	Vendor / Supplier	
Contact Person:	Full Name	
Phone / Email:	(999)999-9999	user_name@email.com
Delivery Address:	Delivery Address	
Expected Delivery Date:	DD/MM/YYYY	

Item	Description	Quantity	Unit Price	Total
Item	Description	Quantity	Unit Price Curr.	Total Curr.
Item	Description	Quantity	Unit Price Curr.	Total Curr.
Item	Description	Quantity	Unit Price Curr.	Total Curr.
Item	Description	Quantity	Unit Price Curr.	Total Curr.
Item	Description	Quantity	Unit Price Curr.	Total Curr.
Item	Description	Quantity	Unit Price Curr.	Total Curr.
Item	Description	Quantity	Unit Price Curr.	Total Curr.
Item	Description	Quantity	Unit Price Curr.	Total Curr.
Item	Description	Quantity	Unit Price Curr.	Total Curr.
Item	Description	Quantity	Unit Price Curr.	Total Curr.
Special Notes / Instructions			**Subtotal:**	Subtotal Curr.
			Tax:	Tax %
			Tax Amount:	Tax Curr.
			Total Amount:	Total Amount Curr.

Authorized Signature:

This Purchase Order is intended for ordering medical supplies, equipment, and consumables for hospitals, clinics, and other healthcare institutions.