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| CITY PHARMACAUTICAL Phone Fax | INVOICE |
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| Customer No  Customer name and address |  |  | Booked by |

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| **SR#** | **Product Name** | **Batch NO** | **QTY** | **Discount** | **Pack size** | **Expiry Date** | **RATE/TP rate** | **Sub Total** |
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| **TOTAL** |  |

Make all checks payable to

Payment is due within 30 days.

If you have any questions concerning this invoice, contact

Thank you for your business!