



B No 033701

OWNER: MEDGRUPPE POLYCLINICS & DIAGNOSTICS CENTER, INC.
 2ND LEVEL, APM CENTRALE ANDRES SORIANO JR. AVE., NRA, MABOLO, CEBU CITY, PHIL. 6000
 TEL. No.: (032) 232 - 2273 • Fax No.: (032) 234 - 2273 Ref. No.: 286411
 VAT REG. TIN: 225 - 095 - 757 - 000

FEB 24, 2020

DATE: _____, 20____

OFFICIAL RECEIPT

CUSTOMER NAME: WITO, JANNAH MARIE GURREA Amount: Three Hundred Seventy-Five and 00/100	TIN: KAMPL	ADDRESS: CEBU CITY
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BUSINESS STYLE:	OSCA/PWD NO.:	SIGNATURE:
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SI NO	SI DATE	DESCRIPTION	SI AMOUNT	PAID AMOUNT
792707	2/24/20	Urinalysis (U/A), DRUG TEST	375.00	375.00

TOTAL SALES	375.00
(VAT INCLUSIVES)	
LESS: 12% VAT	40.18
NET OF VAT/TOTAL	334.82
LESS: SC/PWD DISC.	0.00
TOTAL DUE	375.00
LESS: WITHHOLDING	0.00
TOTAL AMOUNT DUE	0.00
VARIABLE (V)	0.00
VAT EXEMPT (E)	40.18
ZERO-RATED (Z)	375.00
VAT (12%)	
TOTAL	

Mode of Payment: CASH _____ COLLECTION _____
 CARD _____ CHECK No. _____ BANK _____

PRINTER'S NAME: DAYON Enterprises PRINTING PRESS	TIN: 203-757-302-000 NV	ADDRESS: P. Del Rosario St., Cebu City	PRINTER'S ACCREDITATION NO.: 081MP20190000000021	DATE ISSUED: MAR. 28, 2019	EXPIRY DATE: MAR. 28, 2024
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PTU NO. BOUND	BOX/BKLT. NO. 200 BKLTs.	SETS 50	COPIES PER SET 3	SERIAL NO. B30001-B40000	BIR ATP NO. 2AU0002377126	DATE ISSUED 11/20/2019	VALID UNTIL 11/20/2024
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[Signature]
 CASHIER/AUTHORIZED PERSON

THIS OFFICIAL RECEIPT SHALL BE VALID FOR FIVE (5) YEARS FROM THE DATE OF ATP.

MEDGROUP POLYCLINICS & DIAGNOSTIC CENTER, INC.

2nd Level, APM Centrale, A. Soriano Jr. Ave., NRA
 Mabolo, 6000 Cebu City, Philippines
 Tel. Nos. (032) 232-2273 * (032) 266-3245

SERVICE ORDER

SO No.: **0000792707**
 Date: **2/24/2020**
 Ref. No.: **792707**
 Date of Birth: **12/29/98**

Patient Name: **VITO, JANNAH MARIE GURREA**

HMO No.:

Gender **F** Age **21 yrs.old**

Address: **KAMPUHAW, CEBU CITY**

Result: **Patient will pick-up**

Referred by: **IPLOY INC.,**

QTY.	ITEM NO.	DESCRIPTION	DISCOUNT	UNIT PRICE	AMOUNT
1	211	Urinalysis (U/A)	0.00	75.00	75.00
1	1989	DRUG TEST	0.00	300.00	300.00
Other Charges					0.00
Less : Discount					0.00
Total Amount					375.00

Payment Method: **CASH**
 Employer: **IPLOY INC.,**
 Charge To: **PATIENT**
 Remarks: **APRIL**
 Check-up Type: **DIAGNOSTIC**

by 2/24
bronchitis knee
PAID
PRIME CARE CEBU

Customer Signature

Cashier

Verified by

Date printed: **2/24/2020**

Prime CARE
C E B U

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