DATE OF REQUISITION
– –
MONTH DAY YEAR

UNIVERSITY MEDICAL CENTER
PURCHASE REQUISITION

NON-STOREROOM ITEMS ONLY
ONLY ONE VENDOR CAN BE LISTED ON EACH REQUISITION
PLEASE PRINT OR TYPE ALL INFORMATION

PURCHASE REQUISITION NO.
PURCHASE ORDER # ASSIGNED
DO NOT FILL IN SHADED AREAS

DEPARTMENT	LOCATION	COST CENTER NO.	REQUISITIONER	PHONE EXT.	DATE REQUIRED

APPROVAL (PLEASE REFERENCE BACK FOR APPROPRIATE LEVEL OF APPROVAL) | DATE PLACED:

SUGGESTED VENDOR NAME:	PURCHASING DEPARTMENT VENDOR SELECTION	CONFIRMED TO:	TERMS
PURCHASING TO SELECT VENDOR ☐		BUYER:	FOB

LINE NO.	SUB.ACCT.	QTY/UNIT	ITEM DESCRIPTION / CATALOG #	UNIT COST	EXTENDED/COST
			FOR RETURNS ONLY: RGA#		

MSDS SHEET REQUIRED: YES ☐ NO ☐ **TOTAL:**

WHEN REQUIRED CONTRACT REVIEW AND AUTHORIZATIONS NECESSARY

APPROVALS						FINAL AUTHORIZATIONS	
DEPT. DIRECTOR	MAT. MGMT. DIR/DESIGNEE	VICE PRES.	MEDICAL DIRECTOR	LEGAL REVIEW	FINANCE REVIEW	EXECUTIVE V.P. & COO	PRES. & CEO

COMMENTS:

PURCHASING