SHIP TO:

COUNTY HOSPITAL

BILL TO:

COUNTY HOSPITAL

PURCHASE REQUEST

TO: ______________________________

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Phone No. ______________________________

Account No. ______________________________

Order No. ______________________________

Date ______________________________

NOTE: Mark all shipments to the Central Receiving Department.

CHARGE TO	DEPARTMENT	TAX EXEMPT KY	DATE RECEIVED
SHIP VIA	CONF. NO.	ORDERED BY	

QUANTITY	REORDER NO.	DESCRIPTION OF ITEMS OR SERVICE	UNIT COST	TOTAL COST