PAGE_____ OF _____

AGENT

PO#

**SUNY HEALTH SCIENCE CENTER AT BROOKLYN**

**DO NOT FILL IN GREY AREAS**
**Please Type or Print Only**
Read Instructions on Back of Last Copy

**PURCHASE REQUISTION**

☐ EXTERNAL VENDOR
☐ INTERNAL RECHARGE

DATE _____ DEPT _____ HSCB BOX # _____ REQ ☐☐-☐☐☐-☐☐☐☐

| SUGGESTED SUPPLIER | REQUISTIONED BY: NAME: TEL BOX |
|---|---|
| ADDRESS | FINAL DELIVERY POINT (BLDG. ROOM) |
| | PRICES WERE QUOTED BY |
| CITY STATE ZIP | TEL. # DATE |

| ITEM | COMPLETE DESCRIPTION & SPECIFICATIONS<br>JUSTIFICATION LETTERS ATTACH ANY & ALL<br>DO NOT EXCEED 1O ITEMS PER PAGE | QUAN. | UNIT | PRICE PER UNIT | TOTAL |
|---|---|---|---|---|---|
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| USE CONTINUATION FORM IF MORE SPACE IS REQUIRED | | | | **TOTAL** | $0.00 |

CHECK POINTS

SAMI _____

PC _____

Pre enc. _____

COMMENTS

**CHARGE TO**

| ACCOUNT CODE | OBJECT CODE | AMOUNT |
|---|---|---|
| | | |
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| | | |
| | | |

**VENDOR TAX ID NUMBER**

AUTHORIZED SIGNATURE

TITLE

AUTHORIZED SIGNATURE [WHEN SECOND SIGNATURE IS NEEDED]

TITLE

DISCT. _____

FOB SHPG. PT. ☐

FOB DEST. ☐

M ☐

S ☐

W ☐

PURCHASING AGEN

DATE

BATCH TYPE

COMMODITY GROUP NUMBER

CONTRACT NU