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 ATTACH ANY & ALL JUSTIFICATION LETTERS DO NOT EXCEED 1O ITEMS PER PAGE	QUAN.	UNIT	PRICE PER UNIT	TOTAL
USE CONTINUATION FORM IF MORE SPACE IS REQUIRED				**TOTAL**	

CHECK POINTS
SAMI ______________
PC ______________
Pre enc. ______________
COMMENTS

CHARGE TO

ACCOUNT CODE	OBJECT CODE	AMOUNT

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