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 ATTACH ANY & ALL JUSTIFICATION LETTERS DO NOT EXCEED 1O ITEMS PER PAGE	QUAN.	UNIT	PRICE PER UNIT	TOTAL
					$1.00
					$1.00
USE CONTINUATION FORM IF MORE SPACE IS REQUIRED				**TOTAL**	$2.00

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