Print Form

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 Central Stores: Mail to Box 61	REQUISTIONED BY: NAME: TEL BOX
ADDRESS or Hand Deliver to UH B526	FINAL DELIVERY POINT (BLDG. ROOM)
or Fax to:718-270-1266	PRICES WERE QUOTED BY
CITY STATE ZIP	TEL. # DATE

ITEM	COMPLETE DESCRIPTION & SPECIFICATIONS JUSTIFICATION LETTERS ATTACH ANY & ALL DO NOT EXCEED 1O ITEMS PER PAGE	QUAN.	UNIT	PRICE PER UNIT	TOTAL
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
	9200	

VENDOR TAX ID NUMBER Not applicable

AUTHORIZED SIGNATURE

TITLE

AUTHORIZED SIGNATURE [WHEN SECOND SIGNATURE IS NEEDED]

TITLE

You can print, sign, scan then eMail to :
CentralStores@downstate.edu

M ☐
S ☐
W ☐

DISCT. _____
FOB SHPG. PT. ☐
FOB DEST. ☐

PURCHASING AGEN

DATE

BATCH TYPE

COMMODITY GROUP NUMBER

CONTRACT NU