AGENT

SUNY DOWNSTATE Medical Center

PO#

DO NOT FILL IN GREY AREAS
Please Type or Print Only
Read Instructions on *Procurement Webpage (link)*

PURCHASE REQUISITION

☐ EXTERNAL VENDOR
☐ INTERNAL RECHARGE

DATE: DEPT: MailStop #: REQ # ☐☐-☐☐☐-☐☐☐ suffix:

SUGGESTED SUPPLIER	REQUISTIONED BY: NAME: TEL MailStop
ADDRESS	FINAL DELIVERY POINT (BLDG. ROOM)
	PRICES QUOTED BY
CITY STATE ZIP	SUPPLIER TEL #: QUOTE DATE:

ITEM	COMPLETE DESCRIPTION & SPECIFICATIONS ATTACH ANY & ALL JUSTIFICATION LETTERS DO NOT EXCEED 11 ITEMS PER PAGE	QUAN.	UNIT	PRICE PER UNIT	TOTAL
					$0.00
					$0.00
					$0.00
					$0.00
					$0.00
					$0.00
					$0.00
					$0.00
					$0.00
					$0.00
					$0.00
USE CONTINUATION FORM IF MORE SPACE IS REQUIRED				**TOTAL**	$0.00

CHECK POINTS
SAMI: ☐ Initials:
Log: ☐ initials:
Pre enc. ☐ Initials:
COMMENTS:

CHARGE TO

ACCOUNT CODE	OBJECT CODE	AMOUNT

VENDOR TAX ID #: (if known)

AUTHORIZED SIGNATURE:

Name/ Title:

AUTHORIZED SIGNATURE 2: [WHEN SECOND SIGNATURE IS NEEDED]

Name/ Title:

M ☐
S ☐
W ☐

DISCOUNT:
FOB SHPG. PT.:
FOB DEST.:
COMMENT:

AGENT INITIALS:
DATE COMPL:

BATCH TYPE

COMMODITY GROUP # (if known)

CONTRACT NUMBER (if known)