Sutter Health
East Bay Region
With You. For Life.

PURCHASE REQUEST FORM PO#

INSTRUCTIONS: PLEASE - One vendor per purchase request! This form is to be used for all repairs, services and supplies ***NOT*** ordered via RSS, handheld or storeroom replenishment. **PLEASE COMPLETE ALL INFORMATION REQUIRED.**

DATE	DATE MATERIAL REQUIRED	COST CENTER

COMPANY SHIP TO

☐ ALTA BATES ☐ HERRICK CAMPUS ☐ SUMMIT ☑ SMU
☐ SUTTER DELTA ☐ EDEN ☐ SAN LEANDRO ☐ EBMF

REQUESTING DEPARTMENT

ADDRESS	CITY	STATE	ZIP CODE
SAMUEL MERRITT UNIVERSITY - COMPANY 215	*OAKLAND*	*CA*	*94609*

BUILDING	FLOOR	SUITE NO.	PHONE NO.	EXT
3012 SUMMIT ST.	*1/F C-WING*	*G676A*		

VENDOR NAME	PHONE NO.	EXT

ADDRESS	CITY	STATE	ZIP CODE

IS THE ITEM(S) YOU ARE REQUESTING A PHARMACEUTICAL? ☐ YES ☐ NO
(IF YES, PLEASE INDICATE NDC # BELOW)

DOES THIS ITEM REQUIRE AN MSDS FORM? ☐ YES ☐ NO (IF YES, PLEASE HAVE COMPANY PROVIDE ONE)

Tax Does NOT Apply	Quantity	UNIT	CATALOG	NDC #	DESCRIPTION	Sub Account	UNIT COST	TOTAL COST
☐								*$0.00*
☐								*$0.00*
☐								*$0.00*
☐								*$0.00*
☐								*$0.00*
☐								*$0.00*
☐								*$0.00*
☐								*$0.00*
☐					*SHIPPED TO:*			*$0.00*
☐								*$0.00*
☐								*$0.00*
☐								*$0.00*
☐								*$0.00*
☐								*$0.00*
							SUB	*$0.00*
							TAX	*$0.00*
							FREIGHT	
							TOTAL	***$0.00***

NOTE: Policy for disbursement states that two signatures are required for all disbursements. The reviewing and approving signature must always be, at a minimum, one level of management above the requesting signature.

REQUESTED BY	DATE
REVIEWED AND APPROVED BY	DATE

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