IBERIA COMPREHENSIVE COMMUNITY HEALTH CENTER, INC.

PURCHASE REQUISITION

Vender Name: _____ Date: _____

Address: _____ Dept #: _____

_____ P.O. #: _____

Grant: _____

☐ICCHC ☐ACHC ☐SMPCHC ☐MCHC ☐ SSCHCES ☐SSCHC ☐SCHC ☐VPCHC

Expense Category:		G/L ACCT.:	
Quantity	Description	Unit Cost	Total
Equipment Purchases			

☐ New

☐ Existing (Please note reason for replacing and disposition of old equipment below.)

Requested By Date

Supervisor Date

Chief Financial Officer Date

IS/Operations Manager Date

Ordered By Date

Note: *Please complete your purchase requisition along with the cost of each item extended and totaled. Purchase requisitions must be approved before a Purchase Order Number is issued.*

Revised 12/18 JD (PO)