



# Clinical Purchase Request

Requesting Manager: \_\_\_\_\_

PLEASE COMPLETE FOR ALL PURCHASES OVER \$1000, CHANGES TO PAR LEVELS OF MEDICAL SUPPLY INVENTORY, AND ALL OTHER NON-RECURRING MEDICAL SUPPLY PURCHASES

1. Clinical Purchase Request	(Attach Brochure if Available)
*Item Description: _____ _____	
*Item Catalog #: _____	*Piece Price: _____
*Vendor Name: _____	
*Reason For Purchase: _____ _____	
Quantity to Order _____ Current Par Level: _____ Requested Par Level: _____ *Need By ____/____/____	
Signature / Date: _____	

2. Budgetary Analysis	Capital Expenditure as % of Revenue
Budget	_____
Actual Before Purchase	_____
Actual After Purchase	_____
Signature / Date: _____	

3. Purchasing Manager Review	<input type="checkbox"/> Approve as Proposed	<input type="checkbox"/> Decline
<input type="checkbox"/> Return to Requesting Manager with Changes: _____		
Signature / Date: _____		

4. Executive Review	<input type="checkbox"/> Approve as Proposed	<input type="checkbox"/> Decline
<input type="checkbox"/> Return to Requesting Manager with Changes: _____		
Signature / Date: _____		

**\*Denotes required fields**