

**DEPARTMENT OF HEALTH AND MENTAL HYGIENE
OFFICE OF PROCURMENT AND SUPPORT SERVICES
SPECIAL REQUISITION FOR PURCHASE OF TONER CARTRIDGES**

Contact Name:				Phone #:		
Mail Address:				Today's Date:		
Department Name and Code:				Date Required:		
Detailed Reason for the Need to Order Toner Cartridges: 						
Accounting/Funding Information						
Agy (3) M00	Yr (2)	Index (5)	PCA (5)	AObj (4)	Grant PH (2)	Total Amount \$0.00
Requisition Detail						
Manufacturer	Item #	Description			Quantity	Cost Per Item

THE UNDERSIGNED HEREBY CERTIFIES THAT SUFFICIENT FUNDS ARE AVAILABLE AND HAVE ☐ / HAVE NOT ☐ BEEN PROVIDED IN THE BUDGET FOR THE ARTICLES REQUISITIONED HEREIN AND THE ARTICLES LISTED ARE FOR STATE USE.

APPROVED SIGNATURE

BUDGET CERTIFICATION

ENTERED BY: _____ DATE: _____

***Return completed form to the Director of The Office of Procurement and Support Services (OPASS).**