MARYLAND DEPARTMENT OF HEALTH

REQUISITION INPUT FORM	
NAME OF INITIATOR	PHONE NUMBER
TODAY'S DATE (m/d/yyyy)	DUE DATE (m/d/yyyy)
RECOMMENDED VENDOR	CUSTOMER NAME
VENDOR PHONE	CUSTOMER PHONE
VENDOR ADDRESS	DELIVER TO ADDRESS (include room number)
TYPE OF REQUISITION (check one) ☐ RQ ☐ PR ☐ ER ☐ SS ☐ CS ☐ CR	

ACCOUNT/FUNDING INFORMATION

AGY	Dept. Code (6)	YR (2)	Index (5)	PCA (5)	AOBJ (4)	Grant No (6)	Grant PH (2)	Total Amount
MOO		**FY**						$ 0.00

REQUISITION DETAIL

LINE NO	COMMODITY DESCRIPTION - SPECS	QUANTITY	UNIT OF MEASURE	UNIT COST
1				$ 0.00
2				$ 0.00
3				$ 0.00
4				$ 0.00
5				$ 0.00
6				$ 0.00
7				$ 0.00
8				$ 0.00
9				$ 0.00
*	THE ABOVE IS BEING PURCHASED FOR: [Unit and Person(s)]			

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

APPROVED SIGNATURE _____

UNIT HEAD

SPECIFICATIONS ATTACHED: ☐ YES ☐ NO

_____

BUDGET CERTIFICATION

ENTERED BY: DATE: