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**						

REQUISITION DETAIL

LINE NO	COMMODITY DESCRIPTION - SPECS	QUANTITY	UNIT OF MEASURE	UNIT COST
1				
2				
3				
4				
5				
6				
7				
8				
9				
*	THE ABOVE IS BEING PURCHASED FOR:			

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

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BUDGET CERTIFICATION

ENTERED BY: DATE: