College of Pharmacy

PURCHASE ORDER FORM

Account Number: _____ Quote:_____

Account Name: _____

Date: _____ Date Needed: _____

VENDOR INFORMATION

Vendor Name: _____

Address: _____

City: _____

State/Province: _____ Zip/Postal Code: _____

Phone Number: _____

Fax Number: _____

ROUTINE
Generally delivered within two weeks.

EMERGENCY
If needed before two weeks.

Deliver To

Bldg # _____ Room # _____ Lab #_____

Person placing the order _____

Item #	Description	Quantity	Unit Price	Amount
		TOTAL		

Purpose of Purchase: _____

_____

Requested By: _____

Authorized By: _____

The items requested above are for official University business.
Note: Department/Unit Administrative Staff will make a determination about the mode of purchase (E-purchase or P-card).