P.O. #_____ # JHHS CAPITAL EQUIPMENT REQ CAP 007845

REQUISITION FOR PURCHASE/LEASE ORDER

I. EQUIPMENT PLANNING CATEGORY

- ☐ INCREMENTAL BUDGET REQUEST (IBR)
- ☐ BUDGETED MINOR CAPITAL
- ☐ UN-BUDGETED CAPITAL (SPECIAL FUNDS)
- ☐ UN-BUDGETED CAPITAL (CONTINGENCY)
- ☐ CONSIGNMENT CAPITAL (LEASE, LOAN)
- ☐ CASUALTY LOSS

II. EQUIPMENT OWNERSHIP UPON ARRIVAL

☐ JHH ☐ JHU ☐ JHHS ☐ JHBMC ☐ JHMSC

☐ CONSIGNMENT (VENDOR OWNERSHIP)

DURATION _____ mos.

EQUIP VALUE _____

III. EQUIPMENT CUSTODIAN (JHH ONLY)

FUNCTIONAL UNIT # _____

COST CENTER # _____

COST CENTER NAME: _____

IV. FUNDING

☐ BUDGETED FUNDS

CHARGE TO 100-785-000

PROJECT # _____

AFE # _____

LINE ITEM # _____

☐ OTHER HOSPITAL FUNDS

CHARGE TO 100 - _____ - _____

☐ OPERATING BUDGET FUNDS* CONSIGNMENT CASUALTY LOSS, OR LEASE

ACCOUNT # _____ - _____ - _____

V. LOGISTICS (Check if applicable)

☐ 1. SHIPPING REQUEST IS ASSOCIATED WITH THIS REQUEST: # _____

☐ 2. EQUIPMENT OVERHAUL.

☐ 3. THIS EQUIPMENT WILL REPLACE EXISTING EQUIPMENT.

DISPOSITION OF EXISTING EQUIPMENT:

☐ TRADE-IN ☐ KEEP

☐ SURPLUS ☐ CC TRANSFER

VI. ACTION RESPONSIBILITIES (Check all that apply)

☐ INITIAL DELIVERY TO

BLDG. _____ ROOM _____ PHONE _____ PROPERTY TAG or HTE TAG

☐ MUST BE ACCEPTANCE TESTED BY CLINICAL ENGINEERING

☐ MUST BE ACCEPTANCE TESTED BY MAINTENANCE DEPARTMENT.

☐ LOCATION FOR FINAL EQUIPMENT USE

BLDG. _____ ROOM _____ CONTACT _____ PHONE _____

☐ INVOICE APPROVAL BY:

NAME _____ PHONE _____ LOC _____

VII. AUTHORIZATION

A. EQUIPMENT USER _____

DATE _____ PHONE _____

B. FUNCTIONAL UNIT _____

(Administrator/Dept. Head/ V.P.)

DATE _____ PHONE _____

C. DIRECTOR OF CLINICAL ENGINEERING _____

(For Clinical Equipment Only)

DATE _____ PHONE _____

D. MAINTENANCE DEPT _____

(If Uncrating, Assembly, or Installation Required)

DATE _____ PHONE _____

E. CAPITAL ADMINISTRATOR _____

DATE _____ PHONE _____

F. V.P. FACILITIES _____

DATE _____ PHONE _____

G. V.P. FINANCE _____

H. V.P. LEGAL _____

DATE _____ PHONE _____

I. V.P. CORPORATE SERVICES _____

DATE _____ PHONE _____

REFERENCE: FIN005 AND FIN006. MAJOR AND MINOR CAPITAL APPROVALS NEEDED ON CAPITAL REQUISITION.

QTY	CATALOG # / MODEL	EQUIPMENT DESCRIPTION	PRICE EA	TOTAL

Vendor, Address, Phone, Contact Person:

TOTAL

LEVEL OF APPROVAL; IN ORDER		CIRCUMSTANCE		
		MINOR <50,000	MAJOR >50,000	MAJOR >350,000
1	DEPT MGR/NURSE MGR/SUPRV	X		
2	ADMINISTRATOR	X	X	
2	AREA VICE PRESIDENT			X
3	CAPITAL EQUIPMENT ADMINISTRATOR	X		
4	DIRECTOR OF CLINICAL ENGINEERING (for clinical equipment only)	X	X	X
5	VP FACILITIES		X	X
6	VP FINANCE		X	X
7	VP LEGAL		X	X
8	VP OF CORPORATE SERVICES	X	X	X

SPECIAL INSTRUCTIONS:

1. IF QUOTES HAVE BEEN OBTAINED, PLEASE ATTACH TO REQUEST.
2. IF SOLE SOURCE, A LETTER OF JUSTIFICATION MUST ACCOMPANY REQUISITION.
3. ORIGINATOR MUST ALLOW 30-DAY LEAD TIME FROM PURCHASING RECEIPT FOR COMPLETION OF BID PROCESS.
4. IF THIS IS A LEASE, ALL DOCUMENTS MUST BE ATTACHED.