



PURCHASE ORDER FORM

Please print or type.

Date Requested: _____ PI: _____

Contact: _____ Phone: _____ Authorized Signature: _____

Radiation Safety Officer Approval: _____ Study: _____

BILL TO: EBIRE P. O. Box 2339 Martinez, CA 94553-0233 Phone: (925) 372-2363 FAX: (925) 372-2561

SHIP TO: Sacramento VA Medical Center 10535 Hospital Way Mather, CA 95655-1200
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Catalog Number	Description	Qty	Unit Price*	Total
<i>*I certify that a minimum of 3 sources have been contacted for competitive pricing on each item over \$1,500. _____ (PI initial)</i>		Subtotal		
		Tax		
		Shipping/Handling		
		Total		

Vendor: _____ Phone: _____ FAX: _____

Address: _____

Date Required: _____ Shipping: Overnight* 2-Day* Standard
*Additional charges may apply for expedited shipping.

INTERNAL USE ONLY			
VENDOR ACCT#: _____	CONTACT: _____	ACTUAL: \$ _____	
ORDER DATE: _____	BY: _____	EST. DELIVERY DATE: _____	ACCT#: _____
VENDOR REF. #: _____	REIMB: <input type="checkbox"/> MAIL <input type="checkbox"/> HOLD		PO#: _____
(REV. 06.22.00)			