Reset

FLORIDA CLINICAL PRACTICE ASSOCIATION, INC
REQUISITION FOR PURCHASE ORDER

FCPA ACCOUNT #: _____

VENDOR: _____ **QUOTE #:** _____

Attention: _____

ITEM	DESCRIPTION	QTY	PRICE	TOTAL
				$0.00
				$0.00
				$0.00
				$0.00
				$0.00
				$0.00
				$0.00
				$0.00
				$0.00
				$0.00
				$0.00
		0.00	$0.00	$0.00

SHIP TO: _____

Attn: _____

BILL TO: _____

DEPT CONTACTS:

_____

_____

_____

_____

_____

INCLUDE NAME & PHONE NUMBER FOR EACH CONTACT

_____**I certify that if this purchase is for capital items, these expenses are budgeted within our budget for FY 04/05 as an unrestricted OCO.**

_____

AUTHORIZATION **DATE**

fcpa_po_request.pdf