MARYLAND STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE

DHMH 568 (Revised 2/2002)

REQUISITION INPUT FORM								
NAME OF INITIATOR					PHONE NUMBER			
TODAY'S DATE (M/D/YY)					DUE DATE (M/D/YY)			
RECOMMENDED VENDOR					CUSTOMER NAME			
VENDOR PHONE					CUSTOMER PHONE			
VENDOR ADDRESS					DELIVERY TO ADDRESS (INCLUDE ROOM NUMBER)			
TYPE OF REQUISITION CIRCLE 1 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								
REQUISITION DETAIL								
LINE NO	COMMODIT	Y DESC	RIPTION -	- SPECS		QUANTITY	UNIT OF MEASURE	UNIT COST

THE UNDERSIGNED HEREBY CERTIFIES THAT SUFFICIENT FUNDS ARE AVAIL-ABLE 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

BUDGET CERTIFICATION

ellieriteriteb.

DATE:

ENTERED BY: