DEPARTMENT PURCHASE REQUEST

State Form PILOT FORM 6/2023

Indiana State Psychiatric Hospital Network

☐ **EMERGENCY REQUEST**

Department	Requested by	Prepared by	Extension Number	Date Requested (mm/dd/yy)	Date Required (mm/dd/yy)

QTY	UNIT (each, case, box, etc.)	ITEM DESCRIPTION — Must include item/part number, measurements, colors, etc.	UNIT COST	TOTAL COST
1	each	Shipping/Freight		
			Request Total	

Justification: *(Must include who this will benefit, why this product/service is needed, and why it is needed by a specific date or rush order.)*

Please list one (1) supplier for requests under $1,500. Please list four (4) suppliers for products, services, or total requests not available on QPA, through Indiana Correctional Industries, or from Ability Indiana that are over $1,500 (one (1) must be from a certified minority, women or veteran owned business). Please include supplier name, phone number, email address, contact name and cost.

	Supplier #1	Supplier #2	Supplier #3	Supplier #4
Name				
Phone				
Email				
Contact				
Cost				

Supervisor/Department Head Approval	Date (mm/dd/yyyy)
Fiscal Approval	Date (mm/dd/yyyy)
Assistant Superintendent Approval	Date (mm/dd/yyyy)