DEPARTMENT PURCHASE REQUEST

State Form 57353 (1-24)

FAMILY SOCIAL SERVICES ADMINISTRATION
INDIANA STATE PSYCHIATRIC HOSPITAL NETWORK

FISCAL USE ONLY
Requisition Number

☐ **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
				$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
				$0.00
				$0.00
1	**each**	**Shipping/Freight**		**$0.00**
			Request Total	**$0.00**

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)*