Milford Regional Physician Group
The Benchmark for Quality Care

CAPITAL EQUIPMENT REQUEST

Department Name: _____

Department Number: _____

Department Manager's Signature: _____

ITEM: _____**QUANTITY:** _____

SUGGESTED VENDOR: _____

OTHER VENDORS (if known): _____

PRIORITY: _____(Urgent, Essential, Desirable) CPT if applicable:_____

NEW ITEM/REPLACEMENT/ADDITION: _____

ESTIMATED COST: _____

JUSTIFICATIONS: (Focus on patient safety, staff productivity, cost savings)

_____
_____
_____
_____

SPECIFICATIONS:_____
_____
_____
_____

1. If this item was recommended by medical staff, specify by whom: _____
2. If the use of this item requires additional staff or supply costs, attach calculations.
3. If you have received a bid or price guarantee for this item, please attach it.
4. Describe frequency of use: _____

PURCHASING DEPARTMENT USE ONLY

1st Quote $_____
2nd Quote $_____
3rd Quote $_____

APPROVED BY SENIOR MANAGEMENT: _____

DATE OF APPROVAL: _____