PIKES PEAK BOCES

PURCHASE ORDER REQUISITION

VENDOR: ______________________ **P.O. #** ______________________

ADDRESS: ______________________ **DATE:** ______________________

______________________ **NAME:** ______________________

PHONE: ______________________ **PROGRAM:** ______________________

FAX: ______________________ **ORDERED BY:** ☐ AP/AR Office ☐ Originator

Medicaid

	QTY	UNIT	CATALOG NUMBER	DESCRIPTION	UNIT PRICE	TOTAL PRICE
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						

ALL ITEMS WILL BE SHIPPED TO BOCES & DISBURSED TO DISTRICTS.

SUBTOTAL	
SHIPPING	
TOTAL ORDER AMT	

Originator's Signature ______________________ Date ________

District Administrator's Signature ______________________ Date ________

BOCES Administrator's Signature ______________________ Date ________

Account Number:

FUND	LOCATION	SRE	PROGRAM	OBJECT	JOB CLASS	GRANT	AMOUNT	
								(Line #s)
								(Line #s)
								(Line #s)