LOS ANGELES COUNTY
DEPARTMENT OF MENTAL HEALTH
550 SO. VERMONT AVENUE
LOS ANGELES, CA 90020

801.1 Attachment I

SPECIAL REQUEST

SR#_____

DATE:_____

FACILITY NAME _____
ADDRESS _____
REQUESTING UNIT _____
CONTACT PERSON/TEL _____
FAX NO. _____

FUND/ORG
UNIT CONTROL NO.

ACCT.

	ITEM NO.	QTY.	UNIT	UNIT COST	DESCRIPTION	EXT. AMT.	QTY. REC'D.
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							

JUSTIFICATION: _____

AUTHORIZED SIGNATURE: _____ DATE:_____

Vendor Reference: _____
Address: _____
_____
Vendor Contact/Tel: _____

ADMINISTRATIVE SERVICES DIVISION

☐ Approved ☐ Denied ☐ Hold

_____
Signature

_____
Date

PROCUREMENT USE ONLY

ORDER TOTAL		ORDER PROCESSED
Sub Total	$ _____	P.O. #: _____ Person Contacted: _____
Cash Discount	$ _____	Vendor: _____
Tax	$ _____	Terms: _____ Delivery Date: _____
Freight/Labor	$ _____	By: _____ Date: _____
TOTAL AMOUNT	$ _____	

RECEIVED BY:_____ DATE:_____

76S458 MH-269 (10/99)

ADMINISTRATION SERVICES COPY