

SHIPPING REQUEST

PLEASE PRINT OR TYPE. DO NOT WRITE IN SHADED AREAS.

RETURN REPAIR NOTICE

SR

BILL TO: Johns Hopkins Enterprise
 Johns Hopkins Shared Service Center
 P.O. Box 33499
 Baltimore, MD 21218

P.O. # _____

RETURN AUTH. NO. _____

SHIP TO: (CHECK ONE)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
THE JOHNS HOPKINS HOSPITAL 1780 E. FAYETTE STREET BALTIMORE, MD 21231	THE JOHNS HOPKINS OUTPATIENT CTR. 601 NORTH CAROLINE ST. BALTIMORE, MD 21287	JOHNS HOPKINS BAYVIEW MEDICAL CTR. 4940 EASTERN AVE. BALTIMORE, MD 21224	JOHNS HOPKINS COMMUNITY PHYSICIANS _____	OTHER: _____ _____

FILL IN AREAS (NOT) SHADED

RETURN TO: (VENDOR NAME AND ADDRESS)		SHIPPING INFORMATION: SHIP VIA - <input type="checkbox"/> VENDOR PICK UP <input type="checkbox"/> UPS <input type="checkbox"/> AIR EXPRESS <input type="checkbox"/> PARCEL POST <input type="checkbox"/> MOTOR TRUCK CARRIER <input type="checkbox"/> OTHER _____	
		DATE SHIPPED	SHIPPED VIA
		SHIPPING CHARGES:	FREIGHT <input type="checkbox"/> PREPAID <input type="checkbox"/> COLLECT
		NO. OF PIECES	WEIGHT
DRIVER'S SIGNATURE			
DATE	REQUESTED BY	EXT.	DEPARTMENT
		COST CENTER AND EXPENDITURE CODE	
LOCATION OF MATERIAL		AUTHORIZED SIGNATURE	ORIGINAL PURCHASE ORDER NO.

RETURNS ▼

QTY	UNIT OF MEASURE	MANUFACTURER	CATALOG NO.	DESCRIPTION

REASON FOR RETURN:

<input type="checkbox"/> ORDERED IN ERROR	<input type="checkbox"/> OVERSHIPMENT	<input type="checkbox"/> ORDERED WITHOUT APPROVED PURCHASED ORDER
<input type="checkbox"/> OVERSTOCKED	<input type="checkbox"/> RECEIVED BROKEN OR SPOILED	<input type="checkbox"/> OTHER - EXPLAIN _____
<input type="checkbox"/> ORDERED FOR EVALUATION	<input type="checkbox"/> MERCHANDISE OUTDATED	
<input type="checkbox"/> LOANER / RENTAL	<input type="checkbox"/> NOT ORDERED	
	<input type="checkbox"/> NOT AS SPECIFIED - EXPLAIN _____	

PURCHASING DEPARTMENT ACTION - RETURNED FOR:

CREDIT EXCHANGE ESTIMATED VALUE: _____ RESTOCKING CHARGES _____ %

REPAIRS ▼

QTY	MANUFACTURER	MODEL NO.	DESCRIPTION	SERIAL NO.	WARRANTY
					Y N

SPECIFY NATURE OF REPAIR NEEDED - MODIFICATION CALIBRATION OTHER - SPECIFY
 REFURBISH REPAIR

ESTIMATED VALUE: _____

AUTHORIZED VENDOR'S NAME	VENDOR PICK-UP DATE	AUTHORIZED PURCHASING SIGNATURE	DATE
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DATE OF PLR _____ DATE TO MATERIALS HANDLING _____ DATE TO RECEIVING _____