Rehoboth McKinley Christian Health Care Services

REHOBOTH MCKINLEY CHRISTIAN HEALTH CARE SERVICES
EQUIPMENT EVALUATION FORM

Dept. No: _____ Dept. Name: _____

Equipment Description: _____

Equipment: Replacement ☐ New ☐ (check one) Budgeted: Yes ☐ No ☐

Budgeted Quarter: _____ Cost per budget: $_____

MDB Information Network Consulted: Yes ☐ No ☐ N/A ☐

	Quote 1	Quote 2	Quote 3
VENDOR Vendor: Salesperson: Phone No.: Fax No.:	_____ _____ _____ _____	_____ _____ _____ _____	_____ _____ _____ _____
COST:	$	$	$
Annual maintenance cost:	$	$	$
Maintenance cost start date			
Any additional costs such as an interface, attachment, etc.:	$	$	$
Preference of Physician and/or Director (explain below)	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
Compatible with Facility or Current Systems	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

Explanations:

_____

_____

Requesting Director:_____

IT Approval (if needed):_____

Plant Ops Approval (if needed):_____

Admin Council Representative Approval:_____

CEO Approval(if non-budgeted):_____

CFO/Controller Approval:_____

Attachment to RMCHCS Capital Equipment Policy