**Request for Clinic Supplies Not Currently Available from the School Store Form**

*\*\*\*Attach Product Safety Data Sheet and supporting documentation from vendor related to this product*

|  |  |
| --- | --- |
| **Submitted by** |  |
| **Date** |  |
| **Programs to utilize the product:** |  |
| **Proposed Short Product Name for Item** |  |
| **Expanded Product Description** |  |
| **Proposed Vendor and Item Number** |  |
| **Cost per unit** |  |
| **Estimated monthly utilization in units** |  |

* What item(s) does this replace:

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| --- | --- | --- |
| **Item No.** | **Description** | **Quantity on Hand** |
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* Justification for change:
* Explain plan to eliminate existing inventory:
* Training necessary to utilize new product (Faculty/Student/Dental Assistants/Other):

|  |  |
| --- | --- |
| **Approved by (Program Director)** | **Date** |
|  |  |
| **Approved by (Department Chair):** | **Date** |
|  |  |
| **Approved by (Assistant Dean of Clinical Affairs)** | **Date** |
|  |  |

*Approved Copy to be submitted to School Store Manager for entry into Inventory System on behalf of Formulary Committee*