

EXPENSE EQUIPMENT REQUEST
(Used for equipment items less than \$100k)

1. MEDICAL OR DENTAL FACILITY

a. Shipping Address		b. Date	
		c. UIC	d. ACN
e. Branch Medical / Dental Clinic	f. Branch UIC	g. Command Priority	
h. Requesting Department / Division	i. Department / Division Code	j. Quantity	
k. Standard Nomenclature			

2. ITEM DESCRIPTION / SUPPORTING JUSTIFICATION *(How the equipment will be used with general description and characteristics including ALL components and accessories. Attach manufacturer's literature and quotation.)*

a. Essential Characteristics: *(Detailed, nontechnical, functional description, including accessories and options, of the minimum features and capabilities required to enable completion of intended task. Do not use manufacturer specific terms, model numbers, catalog numbers or proprietary information. Description must be generic, not manufacturer specific.)*

b. Will requested items be used in conjunction with other equipment within the entire facility (existing or proposed)? If yes, explain.

c. Is operator Training Required? If yes, describe.

d. Describe the functional requirement and its clinical usage.

e. Provide workload for last 12 months.

f. Is the equipment part of your command's BUMED Business Plan?

g. Suggested Manufacturer	h. Model Number	i. Unit Acquisition Cost
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3. EQUIPMENT

a. Type
 New Expansion Replacement Upgrade

b. For Replacement / Upgrade

(1) Nomenclature		(2) Manufacturer	
(3) Year Purchased	(4) Model Number	(5) Serial Number	(6) DMLSS ECN

c. Proposed disposition of replaced equipment
 Dispose Excess to Command Retain

d. Why retain?

4. BIOMEDICAL ENGINEERING SECTION

a. Point of Contact	b. Telephone Number		
c. Maintenance / repairs will be <input type="checkbox"/> Inhouse <input type="checkbox"/> Contract	d. Annual Contract Cost	e. Training Costs	
f. Utility Requirements Voltage _____ HZ _____ Current _____ Phase _____ Air _____ Water _____ Vacuum _____ Steam _____			

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5. COMPUTER REQUIREMENTS

- a. Are there computer system interfaces required (i.e., CHCS, LIMS, DIN-PACS)? Yes No
- b. Are there LAN Equipment and usage concerns? Yes No
- c. Are there firewall concerns? Yes No
- d. For additional evaluation guidance and more complete checklist of MID review items, visit NMLC's Web page at:
http://www-nmlc.med.navy.mil/gov_only/policies/equip_policies.htm.
- e. If yes to any of the above explain (*use additional sheets if required*)

6. REQUESTING DEPARTMENT HEAD

a. Name	b. E-mail Address		
c. Telephone Number	d. Signature		e. Date

7. SIGNATURES (*Printed Name and Signature*)

a. Biomedical Engineer	d. Signature		Date
b. MID	d. Signature		Date
c. Facilities	d. Signature		Date
d. Equipment Manager	d. Signature		Date
e. Comptroller / Fiscal Officer	d. Signature		Date
f. Supply Officer	d. Signature		Date
h. EPRC Chairman	d. Signature		Date
i. Safety Officer	d. Signature		Date