

# HOSPITAL SHIP EXPENSE EQUIPMENT REQUEST

(Used for equipment items \$100k and above)

## 1. MEDICAL OR DENTAL FACILITY

a. Name and Shipping Address

b. Date

c. UIC

d. Assemblage Number

e. Branch Medical / Dental Clinic

f. NSN

g. Command Priority & RDD

h. Requesting Department / Division

i. Department TAC #/ Division Code

j. Quantity

k. Standard Nomenclature (ECRI Nomenclature from [www.ECRI.org](http://www.ECRI.org))

## 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. General description and characteristics including ALL components and accessories. (Attach manufacturer's literature and quotation.)

b. Suggested Manufacturer (Not guaranteed to be purchased)

c. Model Number

d. Unit Acquisition Cost (Accessories, installation and facility modifications)

e. 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.)

f. General design features required to meet existing installation limitations.

### (1) Maximum dimensions (inches)

(a) Height

(b) Width

(c) Depth

(2) Weight not to exceed

### (3) Electrical Voltage available

(a) VAC

(b) Hz

(c) Amp

(d) Phase

(4) Workload Requirements (i.e., max throughput, max capacity, turnover rate, etc.)

(5) Mounting Requirements (i.e., Seismic, fastened to deck, overhead, bulkhead, etc.)

(6) Will there be any electrical/structural modifications? ☐ Yes ☐ No

Location (Frame Number): \_\_\_\_\_

☐ Electrical

☐ Flooring

☐ Ceiling

☐ Walls

☐ Plumbing

☐ Other

### (7) Utility Requirements

☐ Water

☐ Drain

☐ Heat Dissipation

☐ Temperature Regulation

☐ Gases

### (8) Unit

Hatch-able \_\_\_\_\_ Industrial Support (crane/forklift): \_\_\_\_\_ Hot Work: \_\_\_\_\_ Ventilation Impact: \_\_\_\_\_

(9) Other unique requirements, not previously mentioned (i.e., surge protection, security requirements (locks, cabinets, doors, etc.))

(10) Is the ability of the manufacturer to provide local maintenance and support critical?

☐ Yes

☐ No

(11) If yes, describe the support required, acceptable response time, and any factors an offerer should be made aware of (e.g., limited access to base, citizenship requirements, etc).

MEDICAL OR DENTAL FACILITY	UIC	ACN
<b>3. JUSTIFICATION</b>		
a. Will requested item be used in conjunction with other equipment within the entire facility? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>		
If yes, explain.		
b. Provide information on similar equipment that is currently available at the facility and the usage of that equipment ( <i>existing or proposed</i> ) even if it is in another department.		
c. Is operator training required? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>		
If yes, explain.		
<b>4. EQUIPMENT</b>		
a. Type <input type="checkbox"/> New <input type="checkbox"/> Expansion <input type="checkbox"/> Replacement <input type="checkbox"/> Upgrade		
<b>5. COMPUTER REQUIREMENTS</b>		
a. Are there computer system interfaces required (i.e., AHLTA, CHCS, LIMS, DIN-PACS, Licensing Renewal(s))? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>		
b. Are there LAN Equipment and usage concerns? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>		
c. Are there firewall concerns? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>		
d. If yes to any of the above, explain ( <i>use additional sheets if required</i> ).		
<b>6. FACILITY MANAGEMENT</b>		
a. Is facility modification required (i.e., additional electrical support; plumbing (water, steam, drainage); emergency power, gas (air O <sub>2</sub> vacuum); exhaust additional heating, A/C ventilation; radiation shielding) <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>		
b. Is installation required? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>		
c. List any environmental impacts (increase or decrease) due to the proposed request (i.e., hazardous waste generated, noise levels radiation, ozone depleting substances, etc.)?		
d. Additional considerations not previously mentioned. ( <i>Use additional sheets if required.</i> )		
e. Include DMLSS drawings for all equipment purchases that require facility modification.		
<b>7. BIOMEDICAL ENGINEERING</b>		
a. Maintenance/repairs will be provided by		If yes, estimated cost.
* <i>Independent government cost estimate required for maintenance contracts</i>		
b. Is additional training or TMDE required? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, estimated cost.
c. If maintenance is contracted, will they require ship/base access?	d. Are multi-services (i.e., multiple vendors/contractors) required to perform install/maintenance**? <input type="checkbox"/> Yes <input type="checkbox"/> No ** <i>Do not combine separate services into one line item.</i>	
e. Is BMET training required? <input type="checkbox"/> Yes <input type="checkbox"/> No	f. Is BMET training more cost effective than contract? <input type="checkbox"/> Yes <input type="checkbox"/> No	
g. What type of warranty is required? <input type="checkbox"/> Standard Warranty <input type="checkbox"/> Extended Warranty		
h. Is test equipment required? Source: _____ Quantity: _____ Part Number: _____ Unit Cost: _____		
i. Is connection required to: <input type="checkbox"/> Hospital LAN <input type="checkbox"/> Other Computer System <input type="checkbox"/> CHCS <input type="checkbox"/> N/A <input type="checkbox"/> Web		j. Who will perform installation? <input type="checkbox"/> BMET <input type="checkbox"/> MSC Engineering Staff <input type="checkbox"/> Contractor <input type="checkbox"/> IT Department

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<b>8. SAFETY</b>		
a. Are there any Safety issues or concerns? <i>(If Yes, attach addendum.)</i>		
<b>9. TYPE OF FUNDING:</b>		
<b>10. MSC ENGINEERING STAFF REVIEW</b>		
a. Is American Bureau of Shipping approval required?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
b. Is Coast Guard approval required?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
c. Can electrical requirements be met for new equipment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>11. ADMINISTRATIVE REVIEW</b>		
a. Does equipment have assigned NSN?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
b. Has an ACR been submitted for this equipment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>12. ATTACHMENTS</b>		
<input type="checkbox"/> Facilities Survey <input type="checkbox"/> DMLSS Drawings <input type="checkbox"/> Other <input type="checkbox"/> CBA <input type="checkbox"/> DMLSS Maintenance History <input type="checkbox"/> Manufacturer's Quote <input type="checkbox"/> Manufacturer's Literature		
<b>13. TOTAL COST</b>		
Equipment: _____ Installation/Training: _____ Modification: _____		
<b>14. SIGNATURES (Printed Name (<u>under title</u>), Signature, Phone Number and Date.)</b>		
<input type="checkbox"/> Approve <input type="checkbox"/> Disapprove	Chief Biomedical Engineer	Signature  Phone Number  Date
<input type="checkbox"/> Approve <input type="checkbox"/> Disapprove	Medical Supply Officer	Signature  Phone Number  Date
<input type="checkbox"/> Approve <input type="checkbox"/> N/A <input type="checkbox"/> Disapprove	Supply Officer	Signature  Phone Number  Date
<input type="checkbox"/> Approve <input type="checkbox"/> N/A <input type="checkbox"/> Disapprove	Chief Engineer	Signature  Phone Number  Date
<input type="checkbox"/> Approve <input type="checkbox"/> N/A <input type="checkbox"/> Disapprove	Chief Electrician	Signature  Phone Number  Date
<input type="checkbox"/> Approve <input type="checkbox"/> N/A <input type="checkbox"/> Disapprove	Chief Mate	Signature  Phone Number  Date
<input type="checkbox"/> Approve <input type="checkbox"/> N/A <input type="checkbox"/> Disapprove	Port Engineer	Signature  Phone Number  Date
<input type="checkbox"/> Approve <input type="checkbox"/> Disapprove	Executive Officer	Signature  Phone Number  Date
<input type="checkbox"/> Approve <input type="checkbox"/> Disapprove	Commanding Officer	Signature  Phone Number  Date
<input type="checkbox"/> Approve <input type="checkbox"/> Disapprove	TYCOM	Signature  Phone Number  Date
<b>15. Any additional information prudent to processing request:</b>		

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16. EQUIPMENT ORDERING INFORMATION. *** THE UNIT WILL INCLUDE THE FOLLOWING COMPONENTS:					
MANUFACTURER CATALOG NUMBER/MODEL	NOMENCLATURE	UC	QUANTITY	PRICE	TOTAL
17. MANUFACTURER SHIPPING ADDRESS					
a. Manufacturer Address		Point of Contact:		E-mail:	
		Fax:		Phone:	
b. Shipping Address (Attention):		Point of Contact (TAH):			
		Commercial Phone:		Fax	E-mail:
		Cell Phone		Extension (Internal COMM) Phone:	
18. ADDITIONAL NOTES					
Additional Information is attached for your review:					
<input type="checkbox"/> 1. Vendor Quote (3)					
<input type="checkbox"/> 2. Technical Information					
<input type="checkbox"/> 3. Essential Characteristics (if applicable)					
<input type="checkbox"/> 4. Sole Source Justification (if applicable)					