UR Medical Center
575 Elmwood Avenue
Rochester, New York 14642

SMH 303 - MATERIALS RETURN FORM
Please Type or Print Clearly

Date: ______________________
Completed by: ______________________
Sending Dept.: ______________________
Room Number: ____________ Ext.: ____________
Authorized Signature: ______________________
Method of Shipment: ______________________

Authorized Return #: ____________ Company Phone #: (____) ____________

List Item(s) and Reason for Return:

__________________________________________________________________________
__________________________________________________________________________

Univ. or Hosp.
Account No. ____________ Purchase Order No. ____________ SMH 312
Requisition No. ____________ (As Required) (As Required)

For Billing Purposes
Bill To: University of Rochester, Accounts Payable
1325 Mt. Hope Avenue, Suite 260
Rochester, New York 14620
Plies 1 and 2 - to Receiving with item, Ply 3 - Retain for your files
Rev. 4/92

Received by: ______________________ Date: ______________________
Shipped by: ______________________ Date: ______________________
UPS Zone: ______________________ Wt ea. Pkg: ____________

PLEASE DO NOT WRITE IN AREA BELOW