

U.S. Coast Guard Health Care Equipment Request

A. UNIT INFORMATION: This section is to be completed by the requesting unit.

Unit: Unit POC/Phone Number:	Shipping Address:	OPFAC:
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Equipment to be Replaced:	Manufacturer:	Est. Repair Cost:
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Acquisition Date:	Life Expectancy:
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Planned Replacement:	Emergency Replacement:	New Requirement:
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Supply Source:

Federal Stock NSN:	GSA Contract:	Open Market:
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Equipment Requested:	Manufacturer:	Equipment Cost:
	Model:	

Accessories: 1. _____ 2. _____ 3. _____	Accessory Cost:
Model: _____	
Series: _____	
Cost: _____	

Installation Costs:	YES	NO	Installation Cost:
Any Unusual/Special Requirements:	YES	NO	
Shipping Costs:	YES	NO	Shipping Cost:

Manufacturer's Address:	Total Cost:

MFR's POC:	Telephone:	
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If Sole Source, provide FULL JUSTIFICATION on WHY this is a sole source request.

Comments: (If a replacement, explain why existing equipment is no longer satisfactory. If a new requirement, provide full justification and reference.)

Receiving Unit FAX or E-mail Confirmation on Receipt of Material.

Name and Phone:	Date Received:
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Preparer Signature and Date:	Commanding Officer Signature and Date:
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