PLEASE FAX TO 9382 2150

Note: Requests must comply with guidelines issued on 22/3/01 (including Hospital Policy No 4.1)

Requesting Department or Clinical Program: ________________________________

Function Details:

New or Existing Committee/Event? ______________________________________

Description of Function/Meeting: ________________________________________

Justification for Catering: _____________________________________________

Time and Date of Function/Meeting: _____________________________________

Venue of Function: ___________________________________________________

Details of Catering Required: ___________________________________________

Estimate Number of People: _____________________________________________

Source of Funding: (Please complete A, B or C)

A. If catering is funded by Clinical Program or Department: (show Dept Name & Cost Centre No)

B. If the function is being paid for from Special Purposes Funds: (show name and account number)

C. If catering is privately funded, please complete details of whom should be invoiced:

Requesting Officer: (Please Print)

Name: ____________________________________________ Date: ______________

Telephone: __________________________ Date: ______________

Approval: (Clinical Program Director or E.D.U.)

Name: ____________________________________________ Date: ______________

Signature: __________________________ Date: ______________