

# UCLA Medical Center/UCLA Hospital System

**SECTION 1**

**Client Information (Billing)**

RCHRG ID	Dept Code	Loc.	Account	CC	Fund	Project	Sub	Object
Service Order Request: : <input type="checkbox"/> CATERING <input type="checkbox"/> CAFÉ MED <input type="checkbox"/> STORE ROOM								Order Date:
Type of Service: <input type="checkbox"/> Breakfast <input type="checkbox"/> Lunch <input type="checkbox"/> Box Lunches <input type="checkbox"/> Dinner <input type="checkbox"/> Light Refreshment <input type="checkbox"/> Supplies								
Department:								
Requested by:						Phone:		Fax:
Number of Guests: <b>(Attach List With Names, Titles, Departments/Affiliations)</b>								

**SECTION 2 Event Information**

Name or Type of Event: _____ Detailed Purpose of Meeting/Supplies: _____ _____ Date of Event: _____ Day: _____ Delivery Location: _____ Pick Up By Customer: <input type="checkbox"/> Pick up location: _____	<p><b>Guidelines</b></p> <p><b><u>for USE of University Funds</u></b></p> <ul style="list-style-type: none"> <li>Meetings of a learned society or Organization.</li> <li>Meetings of an administrative nature.</li> <li>Student-oriented meetings</li> <li>Meetings with prospective UCLA Health care donors.</li> <li>Receptions held in connection with the above activities.</li> </ul>				
<p><b><u>Reimbursement for meals:</u></b></p> <p>Attended only by UCLA Healthcare employees from the same location is prohibited when the meal is for the purpose of continuing business as an incidental part of the meal, or when the meeting could have been scheduled during regular working hours.</p>					
Time of Event:	Terms of Payment:	check one	Type of Service:	check one	Separate Charges: (Estimated)
Set-Up _____	1. Cash/Check: _____	_____	1. On China _____	_____	1. Rental: _____
Start _____	2. VISA/MC/AMEX: _____	_____	2. Disposable - Paper _____	_____	2. Floral: _____
Pick Up _____	3. Debit Card: _____	_____	3. Disposable - Plastic _____	_____	3. Labor: _____
	4. Recharge: _____	_____	4. Buffet Style _____	_____	4. Other: _____
	(See Section 1 above)	_____	5. Full Service sit-down _____	_____	
		_____	6. Box Lunches _____	_____	

**SECTION 3**

Description of Service	Unit Price	Amount

SIGNATURE IS REQUIRED BELOW FOR ALL USE OF UNIVERSITY FUNDS

As Official Host of the above event, I approve this expenditure and certify that the expenses are for official University purposes only.

\_\_\_\_\_  
**Signature of Host**

\_\_\_\_\_  
**Print Name of Host**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature Supervisor / Department Head**

\_\_\_\_\_  
**Printed Name of Supervisor / Department Head**

\_\_\_\_\_  
**Date**

Authority for exceptional approval for UCLA Healthcare resides with the President, Provost, Senior Vice President, Chancellors, Principal Officers of The Regents, or the designees.

\_\_\_\_\_  
**Signature of Designee**

\_\_\_\_\_  
**Printed Name of Designee**

\_\_\_\_\_  
**Date**