



HOSPITAL REQUEST FOR DONOR MILK

All orders must be received by 10 am (PST) on Mondays – Thursdays for next day receipt.

Please place orders two days in advance when possible. SEND ALL ORDERS to: Orders@nwmb.org Local deliveries unavailable on Friday

Name of Hospital: _____

Date: _____ Phone: _____

Contact Person: _____ Dept/Unit _____

Address: _____ City: _____

Email: _____ State: _____ Zip: _____

Purchase Order Number: _____ Confirmation FAX # _____

Orders for higher calorie milk (22-24 cal/oz) will be filled based on availability. Requests for specific bottle sizes will be filled based on availability. Confirmation of orders will be made within 24 hours of receipt of order.

Please indicate # of bottles requested:

45 mL (1.5 oz) Plastic Bottle \$7.50 each
19-20 cal (#4520) _____ 22 cal (#4522) _____ 24 cal (#4524) _____

60 mL (2oz) Glass Bottle \$10.00 each
19-20 cal (#6020) _____ 22 cal (#6022) _____ 24 cal (#6024) _____

90 mL (3 oz) Plastic Bottle \$15.00 each
19-20 cal (#9020) _____ 22 cal (#9022) _____

120 mL (4 oz) Glass Bottle \$20.00 each
19-20 cal (#12020) _____

Colostrum 45 ml (1.5 oz) Bottle \$7.50 each (no nutritional data) (#45C) _____

Defatted 60 ml (2 oz) Bottle \$10.50 each (#60D) _____ 120mL (4 oz) Bottle \$21.00 each (#120D) _____

Shipping/Handling/Delivery Fees will be assessed separately.

Hospital Fed Ex Account Number (if applicable) _____

Ship/Deliver to:	Bill to:
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For order or billing questions, please contact Geoff Johnston • PH: (503)-469-0955 FAX: (503) 469-0962
E-Mail: Geoff@nwmb.org