HOSPITAL REQUEST FOR MILK

Important: Orders must be received by 10 am (PST) on Mondays – Thursdays for next day receipt. Please place orders two days in advance if possible. Friday delivery not available.

Name of Hospital:____

Date:____**Phone:**___________________________________

Contact Person:____________________________________**Dept/Unit**______________________________

Address:______________________________________**City:**____

Email:____**State:**______________**Zip:**____________________

Purchase Order Number:_________________________**Confirmation FAX #**___________________________

Please indicate # of bottles requested. 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.

◯ **2oz (60ml) Bottle**; $9.00 each:

19- 20 cal (#6020)__________ **22 cal** (#6022)_____________**24cal** (#6024)___________

◯ **4oz (120ml) Bottle;** $18.00 each:

19-20 cal (#12020**)** _________

◯ **50ml (1.7 oz) Bottle**; $7.61 each

19-20 cal (#5020)___________**22 cal** (#5022)_____________ **24 cal** (#5024)___________

◯ **100ml (3.4 oz) Bottle**; $15.22 each

19-20 cal (#10020) ____________**22 cal** (#10022)_____________

◯ **Colostrum 50 ml (1.7 oz) Bottle:** $7.61 each (no nutritional data) (#50C)_____________

Shipping/Handling/Delivery Fees will be assessed separately.

◯ **Hospital Fed Ex Account Number:**____

Ship/Deliver to:	Bill to:

For order or billing questions, please contact Geoff Johnston • (503)-469-0955 Fax: (503) 469-0962
E-Mail: Geoff@nwmmb.org

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