

**REQUEST FOR PURCHASE BY LEAGUE OF FRIENDS UCKFIELD HOSPITAL**

**From:**

**Department:**

**Date:**

**Item Required:**

**Background information/why needed:**

**How frequently would it be used:**

**Examples of benefits (e.g. patient's experiences):**

**Price/quotation (including and excluding VAT):**

**Any maintenance requirements and costs:**

**Any other funding applied for (please give details):**

**Please return this form to Elaine Mitchell, Uckfield Hospital together with any additional information, pictures/videos to support your application.**

**For use by LOF**

**Bid No** \_\_\_\_\_

**Approved**    **Yes / No**

**Signed** \_\_\_\_\_

**Dated** \_\_\_\_\_