INSTRUCTIONS

UCONN HEALTH

OFFICE OF LOGISTICS MANAGEMENT (OLM)

PAR Request Form – LM-8

Reference #P:

Submit Form:	You must complete this Form On-Line. Hand written Forms will be rejected. Mail, Fax or PDF the entire package to: Fax: 679-1993 or Mail to: MC 2012		
Requester's Name:		Title:	
Department:			
Phone Number:		Fax Number:	
Room Number:		Mail Code:	
Email Address:			
Request:	☐ Add items to PAR Inventory. ☐ Change PAR Quantity. ☐Delete items from PAR Inventory		

Warehouse #	Description	A, B, C	U/M	PAR	Ship-To	Label (Y/N)
Note:	Please use additional sheets as necessary. Please use the same format as above and attach to this original form.					

Special Instructions:

Signatures: Nursing or Clinical	**Date**	**Signatures:** Logistics Management	**Date**
______ 1. Department Manager ______ Typed Name - Mandatory	______	______ 2. Department Manager/Supervisor ______ Typed Name - Mandatory	______