Mini Medical School (MMS) Purchase Request Form

Name _____ **(Last, First) SID** _____

UCR Affiliated Email Address _____ **Phone Number:** _____

Date Request Submitted ____/_____/_____ **Group Name** _____

Name of Project Leader _____ **Director of Training** _____

Preferred Payment Method: ☐ **Cash** ☐ **Personal check** ☐ **Other** _____

Policies:

- Reimbursements are dispersed in the form of a personal check or cash. Other payment methods may result in an additional delay or transaction fee.
- If the board is able to find the item at a significantly lower cost, we will allocate funding based on the lower cost.
- Reimbursements will only be accepted during Weeks 1 through 10 during the UCR Undergraduate quarter system. Requests for reimbursements will not be processed after the Friday of Week 10.
- Personal check reimbursements will need a 2-3 week processing period. Cash reimbursements will need a 3-4 week processing period. Please submit reimbursement requests as soon as possible.
- If a receipt is lost, reimbursements will be provided based on the lowest available price of the item.
- In order to share with future MMS groups, please return all purchased and unused items at the end of the school year.
- Contact us at minimedicalschool@gmail.com with any questions or concerns.

Please use this example to prepare and attach a typed proposal of the needed purchases with this form. With limited funding, these requests will be reviewed and may be approved by the board. Please do not make purchases without prior approval. If you have an urgent request, please contact us at minimedicalschool.ucr@gmail.com

1. Item Requested _____

   Price _____ Possible Vendors _____

   Purpose/ Intent of Use (1000 character limit per item):

   _____

   _____

   _____

   Can this item be shared with other groups? Check a box. YES ☐ NO ☐

TO RECEIVE REIMBURSEMENTS PLEASE SUBMIT THIS FORM **SIGNED WITH AN ACCEPTABLE, ORIGINAL, RETAIL RECEIPT WITHIN 30 DAYS OF ORIGINAL PURCHASE

EXECUTIVE TEAM USE ONLY:

Date Request Reviewed: _____/ _____/ _____ Date Reimbursement Paid: _____/ _____/ _____

Total Requested Funding _____ Consented Reimbursement Amount: _____

Signature of Director of Finances/ Financial Representive:_____

Notes/ Comments:

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