County of Los Angeles
Department of Health Services
Los Angeles General Medical Center
Meal Request Form

Today's Date:	
Department Name:	
Requestor:	**Phone No.**

Function / Event Information		
Function / Event Name:		
Date:	**Time:**	**No. of People:**
Delivery Location:		

Vendor Information	
Name:	
Address:	**Phone No.**
***Total Cost:**	

** Please attach quote. Limited to $500 per event.*

Justification:	

Charge To	
Dept Name:	**Cost Center:**

APPROVALS * *(PRINT AND SIGN)*	
Administrator:	**Date:**
Chief Officer:	**Date:**
Chief Financial Officer:	**Date:**

** All signatures must be obtained before processing.*

- FINANCE USE ONLY -	
Finance Inventory No.	*Incidental: Yes ☐ No ☐*