

Dr. Jose Fabella Memorial Hospital
BUDGETING DEPARTMENT
RECEIVED BY: [Signature] DATE: 8/9/17

PURCHASE ORDER
DR. JOSE FABELLA MEMORIAL HOSPITAL

DR. JOSE FABELLA MEMORIAL HOSPITAL
Office of the Chief Administrative Officer
RECEIVED BY: [Signature]
DATE: 8/11/17 TIME: 4:55 pm

Supplier: **QUALIFIRST HEALTH, INC.**
Address: **Unit 902 Citystate Centre Bldg., 709 Shaw Blvd.
Oranbo, Pasig City Tel. No. 634-17-40**
TIN : _____

P.O. no. : **2017-08-0631**
Date : **August 1, 2017**
Mode of Procurement: **Competitive Public Bidding.**

DR. JOSE FABELLA MEMORIAL HOSPITAL
Accounting Department
RECEIVED

Date: 8/9 Time: 11
By: [Signature]

Gentlemen:
Please furnish this Office the following articles subject to the terms and conditions contained herein.

Place of Delivery: Materials & Management Department Delivery Term: Seven (7) working days
Date of Delivery: _____ Payment Term: _____

Stock No.	Unit	Description	Quantity	Unit Cost	Amount
	tablet	Co-Amoxiclav (Amoxicillin + Potassium Clavulanate), amoxicillin (as trihydrate) + potassium clavulanate, oral 500mg + 125mg, 625mg, tablet (Qualiclav) (Mfd By: Alkem Laboratories Ltd.,- India)	12,500	7.88	98,500.00
<p>Price list for Drugs and Medicines. Public Bidding dated December 22, 2016.</p> <p>Page 6 No. 57</p> <div data-bbox="485 1058 867 1226" data-label="Form"> <p>DR. JOSE FABELLA MEMORIAL HOSPITAL PROCUREMENT DEPARTMENT RECEIVED BY: <u>[Signature]</u> DATE: <u>8/9/17</u> TIME: <u>10 AM</u></p> </div> <div data-bbox="396 1236 842 1373" data-label="Form"> <p>DR. JOSE FABELLA MEMORIAL HOSPITAL OFFICE OF THE MEDICAL CENTER CHIEF Received by: <u>[Signature]</u> Date: <u>8/8/17</u> Time: <u>10:30 AM</u></p> </div> <div data-bbox="948 1194 1346 1373" data-label="Form"> <p>Dr. Jose Fabella Memorial Hospital FINANCE SERVICE RECEIVED BY: <u>[Signature]</u> DATE/TIME: <u>8/8/17 9:05</u></p> </div>					

(Total Amount in Words) **NINETY EIGHT THOUSAND FIVE HUNDRED PESOS ONLY****

In case of failure to make full delivery within the time specified above, a penalty of one-tenth (1/10) of one percent for every day of delay shall be imposed.

Date P.O. Served: _____
Date of Delivery : _____
Time of Delivery : _____
Signature : _____

Very truly yours,
[Signature]
ESMERALDO T. ILEM, M.D.
Medical Center Chief II
Authorized Official

Conforme: _____
Signature over Printed Name of Supplier
Date

Funds Available: [Signature]
MERCILITA D. FORTIER
Accountant IV

OR/BUR No. 02-2017-03-2017-08-0140
Amount : 98,500.00