

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
PhilHealth Regional Office - Cordillera Administrative Region
 4/F SSS Bldg., Harrison Road, Baguio City
 Tel. # (074) 444-5345/446-0371

POMM-P-006

PURCHASE ORDER

Supplier: <u>DE GUZMAN DRUG</u>	P.O. No.: <u>P-13-064</u>
Address: <u>Maharlika Livelihood Complex, Baguio City</u>	Date: <u>7-Oct-13</u>
Tel./Fax No.: <u>444-9737</u>	Term/s of Payment: <u>on account</u>
Supplier Registered with: _____	Mode of Procurement: <u>small value</u>

Please deliver to this office within 7 days from receipt hereof the following:

NO.	QTY	UNIT	ITEM DESCRIPTION	UNIT PRICE	TOTAL AMOUNT
1	300	tab	Biogesic, 500mg	2.95	885.00
2	200	tab	Neozep, Non-Drowse, 10mg/500mg	4.67	934.00
3	129	tab	Buscopan, 10mg	20.75	2,676.75
4	120	tab	Celestamine, 250mg/2mg	20.20	2,424.00
5	99	tab	Bioflu	6.37	630.63
6	129	tab	Kremil-S chewable	4.90	632.10
7	312	cap	Ponstan SF, 500mg	30.35	9,469.20
			TOTAL		17,651.68
			Less: 5% Final Tax	788.02	
			1% EWT	157.60	
			Net of Tax		16,706.06

Terms & Conditions:

1. Purchase Order (PO) shall be accepted by the supplier before the delivery of goods and/ or services.
2. NO price increase shall be made by the supplier within seven (7) days from the date of the acceptance of P.O.
3. Non-availability of stock shall be made known to PhilHealth before the acceptance of PO.
4. PhilHealth shall have the right to reject and return the items and cancel the corresponding PO if goods delivered are defective, incomplete, non-compliant as to specification when quoted.
5. In case of returned/ rejected items which cannot be replaced within seven (7) calendar days from notice, PhilHealth shall demand full refund of payment made "in cash" or "in check" three (3) calendar days.

Very truly yours,

[Signature]
IMELDA CRISTETA D. VILLAMAR
 Division Chief, MSD

Certified Budget Available <i>[Signature]</i> LILIBETH M. PALACI Fiscal Examiner A/ Budget Officer - Des.	Funds Available in the amount of: PHP 17,651.68 <i>[Signature]</i> MARIA LINDA H. GADINGAN Fiscal Controller III	APPROVED: <i>[Signature]</i> JERRY F. IBAY Regional Vice President
Within the COB: <u>2013</u> Expense Code: <u>774-0</u> Budget: _____ Remarks: _____		Date: _____
Conformance: _____ Signature over Printed Name and Position of Authorized Representative.		
Remarks: _____		

Received Copy of P.O. on _____	CONFORME: <i>[Signature]</i> BRUNCE RAMOS 10-9-13 Print Name and Signature of Supplier/Representative CERTIFIED TRUE COPY
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