**Department of Family Medicine**

**Ordering from *At Your Service* Catering**

* As the requestor, you should first visit the website to view menu and cost: <https://www.uclahealth.org/catering>
* Contact catering to discuss details of your event. They will create an At Your Service Catering form and will email it to you (see next page for an example).
* Have your Authorizer (PI or other assigned authorizer) review and approve
* Once you have approval, then the contact person (usually the requestor) should sign as the “host.”
* Submit to Fund Manager.
* Fund Manager will review and sign off, and then return a copy of the signed form via email to both the requestor (to confirm order with catering) and Valencia (to process the internal recharge)
* Valencia will place the online recharge order.
* The requestor should confirm the order with catering 2-3 days before event

Ronald Reagan UCLA Medical Center

Department of Nutrition / At Your Service Catering Services

Section 1 - Client Information (Billing)

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Recharge ID | | Dept. Code | | | | | | Loc | Account | | | | | | | | CC | | Fund | | Project | | | Sub | | | | | Object |
| Service Order Request:CateringCafé Med  Store Room | | | | | | | | | | | | | | | | | | | | | **EMAIL:** | | |  | | | | | |
| Type of Service:Breakfast  Lunch  Box Lunches  Dinner Light RefreshmentSupplies | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Department:** | | | |  | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Requested By:** | | | |  | | | | | | | | | | | | | | **Phone:** | |  | | | | | **Fax:** | |  | | |
| **Number of Guests:** | | | |  | | | | | | | (Attach List With Names, Titles, Department/Affiliations) | | | | | | | | | | | | | | | | | | |
| SECTION 2 – Event Information | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name or Type of Event:** | | | | | | |  | | | | | | | | | | | | | | | | Guidelines for Use ofUniversity Funds  * Meetings of a learned society or organization * Meetings of an administrative nature * Student-oriented meetings * Meetings with prospective | | | | | | |
| **Detailed Purpose of Meeting/Supplies:** | | | | | | | | | | | |  | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | |
| **Date of Event:** | |  | | | | | | | | | | | **Day:** | | |  | | | | | | |
| Delivery Location: | | |  | | | | | | | | | | | | | | | | | | | |
| **Pick Up By Customer:** | | | | | | **Pick Up Location:** | | | | | | | | |  | | | | | | | |
| **Time of Event** | | | | | **Terms of Payment** | | | | | **Check** | | | | **Type of Service** | | | | | | **Check** | | **Separate Charges (Estimated)** | | | | | | | |
| Set-Up: |  | | | | 1. Cash/Check | | | | |  | | | | 1. On China | | | | | |  | | 1. Rental: | | | |  | | | |
| **Start:** |  | | | | 2. VISA/MC/AMEX: | | | | |  | | | | 2. Disposable-Paper | | | | | |  | | 2. Floral: | | | |  | | | |
| Pick-Up |  | | | | 3. Debit Card: | | | | |  | | | | 3. Disposable-Plastic | | | | | |  | | 3. Labor: | | | |  | | | |
|  | | | | | 4. Recharge: | | | | |  | | | | 4. Buffet Style | | | | | |  | | 4. Other: | | | |  | | | |
| (See Section 1 above) | | | | |  | | | | 5. Full Service Sit-Down | | | | | |  | |  | | | | | | | |
|  | | | | | | | | | 6. Box Lunches | | | | | |  | |
| SECTION 3- Description of Service | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | Unit Price | | | | Amount | |
|  | | | | | | | | | | | | | | | | | | | | | | | |  | | | |  | |
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| SIGNATURE IS REQUIRED BELOW FOR ALL USE OF UNIVERSITY FUNDS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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**UCLA Medical Center/UCLA Hospital System**

**Catering Request Form**

As Official Host of the above event, I approve this expenditure and certify that the expenses are for official University purposes only.

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| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| Signature of Host |  | Printed Name of Host |  | Date |
|  |  |  |  |  |
| Signature of Supervisor/Department Head |  | **Printed Name of Supervisor/Department Head** |  | Date |
| Authority for exceptional approval for UCLA Healthcare resides with the President, Provost, Senior Vice President, Chancellors, Principal Officers of the Regents, or their designees. | | | | |
|  |  |  |  |  |
| Signature of Designee |  | Printed Name of Designee |  | Date |

RONALD REAGAN UCLA MEDICAL CENTER

AT YOUR SERVICE CATERING SERVICE

757 Westwood Boulevard Los Angeles, Ca. 90095

# Ronald Reagan UCLA Room B147B - Office 310-267-9212 - Fax 310-267-3895