

**CENTRAL STATE HOSPITAL
BOBBY E PARHAM COOK-CHILL FACILITY
CATERING EVENT REQUEST FORM**

Date:

<u>Department Requesting Event:</u>	<u>Function Date:</u>	<u>Date and time to be picked up from food service:</u>
<u>Contact Person & Telephone No.</u>	<u>Location:</u>	
<u>Type of Event</u>	<u>Number of People Expected</u>	
<u>Number of Tables Needed</u>	<u>Configuration of Tables</u>	
<u>Requested Menu:</u>		
<u>Billing Information</u>		
<p>NOTIFICATIONS: _____</p> <p style="text-align: center;">UNIT DINING ROOM STAFF/MANAGER DATE</p>		
<p>APPROVED BY: _____</p> <p style="text-align: center;">DEPARTMENT HEAD/DIVISION CHIEF/OFFICE DIRECTOR DATE</p>		
<p>APPROVED BY: _____</p> <p style="text-align: center;">STATEWIDE FOOD SERVICE DIRECTOR DATE</p>		

*All requests require a 30-day notice.