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UNIVERSITY OF IOWA HEALTHCARE
SHIPPING ORDER FORM
SHIPPING & RECEIVING 1002 SRF (319) 356-2389

Please submit 2 copies of this form to Shipping & Receiving

DEPARTMENT INFORMATION

Date _____

Shipper Name _____

Department _____

Room No. _____ Building _____

Phone (319) _____

Bill Shipping Charges to :

UIHC Fedex/UPS Acct No. _____

Recipient Acct. No. _____

Third Party Acct. No. _____

SHIP TO (to be completed by hospital department)

Name of Person _____

Name of Company _____

Street Address _____

(NO P.O.BOXES)

City _____ State _____ ZIP _____ - _____

Country (if international) _____

Phone No. _____

(REQUIRED FOR INTERNATIONAL SHIPMENTS)

Return Authorization Number

(or name of person

authorizing return) _____

ARTICLES SHIPPED (to be completed by hospital department) **NO CASH ALLOWED**

ITEM DESCRIPTION (Quantity & Description)	DECLARED VALUE	DRY ICE (lbs)

Carrier Type Requested

Air Freight **(must be at Shipping & Receiving office no later than 3:00p.m.)**

☐ Next Day Service

☐ Ground Service

☐ 2nd Day Service

☐ Saturday Delivery
(extra charge)

Carrier _____ Cost _____

Received by/Date _____ Weight _____