

CAPITAL EXPENSE EQUIPMENT PROGRAM (CEEP) REQUIREMENT

(\$2,500.00 to \$49,999.99)

1. ACTIVITY <i>(Name and Installation)</i>	2. FROM <i>(Division/Department/Service)</i> Hand Receipt Number:	3. RCN CONTROL NUMBER <i>(For Logistics Division use only)</i>	4. DATE
5. STANDARD ITEM DESCRIPTION OR GENERIC NOMENCLATURE: <i>(Appen N, SB 8-75-MEDCASE)</i>		6. POINT OF CONTACT & PHONE NUMBER Name: Commercial Phone Number:	
7. EXTENDED OR SYSTEM DESCRIPTION <i>(Attach a picture and specifications of the item.)</i>			
QUANTITY: UNIT PRICE:			
8. JUSTIFICATION			
a. HOW IS THE FUNCTION NOW BEING ACCOMPLISHED?			
b. WHY IS THIS EQUIPMENT REQUIRED? <i>(E.g., workload data, new technology, cost reduction, maintenance costs, equipment down-time or nonavailability, obsolescence of current methods, or other facts which demonstrate cogent reasons for your requirement.)</i>			
9. ITEM TO BE REPLACED <input type="checkbox"/> YES <input type="checkbox"/> NO NSN: MMCN: Nomenclature: Serial Number: Model Number: Location:	10. EQUIPMENT REQUIREMENTS <input type="checkbox"/> Additional electrical support or emergency power <input type="checkbox"/> Water, drainage or steam <input type="checkbox"/> Exhaust <input type="checkbox"/> Gas (air, oxygen, vacuum, propane, etc.) <input type="checkbox"/> Emits radiation, microwaves, radiowaves, laser or has radioactive materials as component <input type="checkbox"/> Unusually heavy/bulky <input type="checkbox"/> Requires installation <input type="checkbox"/> Heating, ventilation, or air conditioning <input type="checkbox"/> Other:	11. INFORMATION MANAGEMENT AREA EQUIPMENT (IMAE) REQUIREMENTS a. <input type="checkbox"/> No IMAE <input type="checkbox"/> Embedded IMAE <input type="checkbox"/> Enhanced IMAE <input type="checkbox"/> Supplemental IMAE <input type="checkbox"/> Other: b. Information mission area documentation and approval UP AR 25-5 is required. <input type="checkbox"/> Yes <input type="checkbox"/> No c. If yes, complete and accurate IMA documentation is attached. <input type="checkbox"/> Yes <input type="checkbox"/> No	
12. MEDICAL MAINTENANCE REVIEW		13. HOSPITAL ENGINEER REVIEW	
a. Did you see problems with providing maintenance support; i.e., parts, TMDE? <input type="checkbox"/> No <input type="checkbox"/> Yes (Explain on separate sheet) b. Subsystem: <input type="checkbox"/> A <input type="checkbox"/> B c. Maintenance will be provided: <input type="checkbox"/> In house <input type="checkbox"/> Service contract (Est annual cost: \$ _____) d. Replaced item: Make/Model: _____ Life expectancy: _____ Date in service: _____ Maint Exp Limit: _____ Current Exp: _____ e. The justification provided has been reviewed and the statements regarding maintenance have been verified. The replacement of the item <input type="checkbox"/> is <input type="checkbox"/> is not supported based upon maintenance considerations.		a. Are site modifications, utilities, or other costs involved? <input type="checkbox"/> No <input type="checkbox"/> Yes (Explain on separate sheet) b. Estimate of site preparation costs: \$ _____ c. Action has been taken to develop site plans and to provide resources to assure equipment will be installed when received: <input type="checkbox"/> No <input type="checkbox"/> Yes (Explain on separate sheet) <input type="checkbox"/> N/A	
15. I CERTIFY THAT THE INFORMATION ON THIS FORM IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. <i>(Signature, Typed Name & Title of Requestor)</i>		14. PRIORITY <i>(Assigned by individual signing in block 16)</i> This is prioritized as number ____ of ____ CEEP requirements submitted by this division/department/service.	
16. THIS EQUIPMENT IS NECESSARY FOR THE ACCOMPLISHMENT OF THIS ACTIVITY'S MISSION. <i>(Signature, Typed Name & Title of Chief of Division/Department/Service)</i>			