

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

**Date:**

<u>Department Requesting Event:</u>	<u>Function Date:</u>	<u>Time to Be Set up By:</u>
<u>Contact Person &amp; 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>		
<b>APPROVED BY:</b> _____ DEPARTMENT HEAD/DIVISION CHIEF/OFFICE DIRECTOR <span style="float: right;">DATE</span>		
<b>APPROVED BY:</b> _____ STATEWIDE FOOD SERVICE DIRECTOR <span style="float: right;">DATE</span>		

\*All request require 48-hour notice.