|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Request Type** | | Choose an item. | | **If Request Type is Change or Inactivate, enter existing Cost Center No.** | | | | | |  |
| **Cost Center Data** | | | | | | | | | | |
| Type: | | | CAPITAL | | | | | | | |
| Name: | | |  | | | | | | | |
| Description: | | |  | | | | | | | |
| Cost Center: | | |  | | | | | | | |
|  | | |  | | | | | | | |
| Address: | | |  | | | | | | | |
| City: | | |  | | State: | |  | Zip Code: | |  |
| Person Responsible: | | |  | | | | | | | |
| Position Responsible: | | |  | | | | | | | |
| Justification for Cost Center: | | |  | | | | | | | |
| **Requested by** | | | | | | | | | | |
| Name: |  | | | | | Telephone: | | |  | |
| Email: |  | | | | | Date: | | |  | |
| **Approved by** | | | | | | | | | | |
| Name: |  | | | | | Telephone: | | |  | |
| Email: |  | | | | | Date: | | |  | |

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| --- | --- | --- | --- |
| Signature: |  |  |  |

*\*Signature is not required if form is emailed from the authorized approver.*

|  |  |  |
| --- | --- | --- |
| **Return Approved** | | DOA-OSRAP-ORGN@la.gov |
|  |  | |
| **Questions:** | | Call: 225.342.1097 |

|  |  |
| --- | --- |
| REQUEST TYPE | **New Cost Center** – Select when adding a **new** Capital Cost Center that does not exist in SAP.  **Change Cost Center** – Select when changing an **existing** Capital Cost Center in SAP.  **Inactivate Cost Center –** Select when inactivating an **existing** Capital Cost Center inSAP. |
| IF REQUEST TYPE IS CHANGE OR INACTIVATE | Field length (10). Alpha/numeric. Enter the existing Capital Cost Center that needs to be changed or inactivated. |
| COST CENTER TYPE | Defaults to CAPITAL. |
| COST CENTER NAME | Field length (20). Alpha/numeric. Enter the Cost Center name. |
| COST CENTER DESCRIPTION | Field length (40). Alpha/numeric. Enter the Cost Center description. |
| COST CENTER | Field length (10). Alpha/numeric. Enter the requested Cost Center.  The **Business Area** and **Appropriation Unit** should be entered in the first 6 positions (i.e., 270TF0XXXX). |
| ADDRESS/CITY/STATE/  ZIP CODE | Enter the appropriate street address, city, state, and zip code for the requested Cost Center. |
| PERSON RESPONSIBLE | Enter the title of the position that is responsible for the requested Cost Center. |
| POSITION RESPONSIBLE | Field length (8). Enter the numeric position number that is responsible for approval of SRM Shopping Carts for the requested Cost Center, if applicable. |
| JUSTIFICATION FOR COST CENTER | Enter a brief explanation describing your need for the requested Cost Center. |
| REQUESTED BY | Enter the name, telephone number, and email address of the person preparing this form; enter the date the form is being prepared. |
| APPROVED BY | Enter the name, telephone number, and email address of the person approving this form; enter the date the form is being approved. |
| RETURN | Return approver signed forms via email to OSRAP. Signature is not required if form is emailed directly from the authorized approver. |

**CAPITAL COST CENTER MASTER RECORD REQUEST INSTRUCTIONS**