

Vendor Qualification

Date: _____

1. Company Information

Name and complete mailing address for bidding and purchase orders:

HUMC's preferable method of purchasing processes is electronic submission. Please provide us with a valid email address for delivery of purchase orders: _____

Phone number: _____

Fax number: _____

Mailing address for payments (if different than above):

Any other name and address your company is currently doing business under or has previously done business under:

Number of employees: _____

Number of clients _____

Number of business locations _____

How long your Company is in business _____



2. Category-Identify the type of services provided by your Company
Category (i.e.: Medical Surgical, Orthopedic, Contractor, Office Supplies.....)

_____Manufacturer

_____Distribution

_____Other (Specify)

Specify Category_____

3. Website Address _____

4. D&B Number _____

5. Tax Identification Number _____

6. Company Affiliations- Identify any companies that your firm is legally affiliated with and type of relationship; be detailed in your response to include company name, address, and principal contacts.

7. Professional Affiliations- Identify all professional trade organizations, your company are affiliated with:

8 Key Personnel- Provide the key individuals within your organization including but not limited to Owner, President, Vice President of Sales, CFO, Sales Representative, Customer Service Contact, Regional Manager, and Accounts Payable contact.

9. Type of Organization:

_____ Individual

_____ Partnership

_____ Not for profit organization

_____ Corporation, Incorporated under the laws under the State of _____

_____ Small Business (small business as defined by small business regulations)

_____ Women Owned business

_____ Minority owned business

10. Provide a list of Individuals authorized by your Company to sign bids and make offers to the Medical Center. _____

11. How and/or by whom where you referred to Hackensack University Medical.

12. Group Purchasing Contracts- Identify all Group Purchasing organizations which you participate with.

13. Provide a list of reference clients in New Jersey, New York and Pennsylvania and the number of years of service in each organization.

14. Sanction- A statement is attached regarding sanctions by the Government; the attached document must be completed and returned with your Vendor Qualification Form.

15. Payment Terms- Hackensack University Medical Center offers payment terms of Net 90 days. Payment days are based on the day the invoice is received by the Medical Center, not the date the invoice is generated by your company. All invoices must include the Medical Center purchase order number; any invoices without this information will be rejected and returned to your company. Rejected invoices will not be used in calculated payment days.

Acknowledge your understanding and acceptance of this requirement by initialing.
_____Accepted.

16. Hackensack University Medical Center will not accept finance charges or late fees for payment of invoices beyond contract payment terms for any reason. Our organization requires a quarterly meeting with its Business Partners should there be any issues regarding invoice payment activity.

Acknowledge your understanding and acceptance of this requirement by initialing.
_____Accepted.

17. FOB- Hackensack University Medical Center requires all shipments to be FOB destination.

Acknowledge your understanding and acceptance of this requirement by initialing.
_____Accepted.

18 Freight Charges- Hackensack University Medical Center requires the freight charges be the responsibility of the Business Partner.

Acknowledge an understanding and acceptance of this requirement by initialing.
_____Accepted.

19. Authorization to Contract- Hackensack University Medical Center requires all contracts for materials, equipment and service to be authorized by the Vice President of DSS, CDM, Materials Management and Budget of the Medical Center. All vendor documents and/or Medical Center purchase order documents require the signature of the Vice President of DSS, CDM, Materials Management and Budget. Any documents accepted by a company without this authorization will be invalid and by acknowledging this requirement on the vendor qualification form you have agreed not to hold the Medical Center liable for any materials and/or services in the event proper authorization was not obtained.

Acknowledge your understanding and acceptance of this requirement by initialing.
_____Accepted

20. As a vendor doing business with Hackensack University Medical Center you agree to the following: No supply item sold by your company is to expire on our shelves. Any expired good is either credited or exchanged for useful product in a timely manner. HUMC will not pay any restocking fee if an item is returned to the company for any reason.

Acknowledge an understanding and acceptance of this requirement by initialing.
_____Accepted



21. Authorization to Purchase The Purchasing department at Hackensack University Medical Center is the authorized agent to make purchase commitments. All materials, services and equipment being obtained by the Medical Center must be acquired on authorized purchase orders. The cost related to any supplies, services and/or equipment provided to the Medical Center by a vendor who has not obtained an authorized purchase order will be the responsibility of that vendor.

Acknowledge your understanding and acceptance of this requirement by initialing.
_____Accepted.

22. Use of Price Information for Benchmarking or Analysis- Hackensack University Medical Center may use all price and cost information received from a business partner for the purpose of benchmarking and/or analysis. Price information will be kept confidential by HUMC and only be used for the benefit of HUMC. Third party software may be used for benchmarking and analysis activity and HUMC will require all third parties to execute a confidentiality agreement

Acknowledge your understanding and acceptance of this requirement by initialing.
_____Accepted

23. Introduction and Evaluations- Any product or service being introduced to the Medical Center must be presented to the Purchasing department. Discussions your representative may have with any other department in the Medical Center must not occur prior to your introduction through the Purchasing department.

Products for evaluation will be arranged through the Purchasing department and require a no charge purchase order.

Acknowledge your understanding and acceptance of this requirement by initialing on the accepted line:
_____ Accepted

24. W9Form- the attached W9 Form must be completed and returned with your response.

25. Conflict of Interest- Please answer all of the following questions and provide additional information to any **YES** answers:

- A. Does your company and or any principals within your organization have a personal or business relationship with any Hackensack University Medical Center employee, Board Member, or any family member of any of the Medical Center Boards?

_____Yes _____No

B. Does your organization or any of the principals within your organization have a personal or business relationship with any vendor currently doing business with Hackensack University Medical Center or any vendor who has previously done business with the Medical Center?

_____Yes _____No.

C. Do any principals within your organization have personal or business relationship with any Group Purchasing Organization doing business with the Medical Center?

_____Yes _____No.

D. Do any principal individuals within your organization participate on any Hackensack University Medical Center committees or serve on any Medical Center Boards?

_____ Yes _____No

E. Does your organization or any of its principals have a personal or business relationship with any member of the HUMC Medical Staff inclusive of but not limited to employment, consulting, research, or speaking engagements?

_____Yes _____No.

F. Is your organization or any of its principals in a position to make referrals to or receive referrals from HUMC?

_____Yes _____No

G. Does your organization or any of its principals provide services which compete with Medical Center activities either directly or indirectly?

_____Yes _____No

H. Are you currently or have you been previously employed by HUMC?

_____Yes _____No

If you answered Yes to any of the questions regarding Conflict of Interest, please explain fully below:

26. By signing you are certifying below that you agree that your company and their agents, will adopt Hackensack University Medical Center policies regarding compliance with Section 6032 of the Deficit Reduction Act of 2005. Vendor further acknowledges that they have made these policies available to their employees and managers. The policies can be accessed via the internet at <http://www.hackensackumc.org/about-us/corporate-compliance>

_____/Signature

27. What health insurance plans to you offer your local employees?

28. How many employees do you have locally?

29. Who is the main contact at your firm responsible for the purchasing of health insurance?

30. Would you be interested in hearing about new health insurance concepts and programs for your employees?

Yes_____

No_____

On a scale of 1 to 5 with 5 be the highest, as an employer how important is it to you that your insurer has Hackensack University Medical Center in its networks?

Please circle one 1 2 3 4 5

Hackensack University Medical Center has established a toll-free hotline available to our business partners as part of the Corporate Compliance Program. **The Hotline Number (888-411-0012) and is available 24 hours a day, seven (7) days per week.** Vendors are encouraged to use the hotline to report violations of laws or regulations or unethical business practices of any kind. All calls will be responded to by Compliance Department staff and will be treated confidentially to the extent permitted by law.

The information supplied on this vendor qualification form has been provided to comply with the Hackensack University Medical Center requirements for Business Partners. The information provided within this document is accurate and true.

Company Name: _____

Print/Type Name and Title _____
Authorized Company Representative

Email Address: _____ Direct Contact # _____

Signature _____

Date: _____