Vendor Qualification

Date: _____

1. **Company Information**

Name and complete mailing address for bidding and purchase orders:

_____

_____

_____

Phone number_____

Fax number_____

Mailing address for payments (if different than above):

_____

_____

_____

2. Tax Identification Number. _____

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

_____

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

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

6. Conflict of Interest- Please answer all of the following questions and provide additional information in the space provided for 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. Does your organization or any of its principal provide services which compete with Medical Center activities either directly or indirectly?

_____Yes _____No

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

_____Yes _____No

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

_____Yes _____No

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

_____
_____
_____
_____

7. 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 www.humc.com.

_____/Signature

HUMC payments terms are Net 90.

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

_____

9. How many employees do you have locally?

_____

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

_____

11. 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

Revised 5/02/11.

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: _____