

INTRODUCE YOUR PRODUCTS AND SERVICES TO ORLANDO HEALTH

REQUEST DATE:

Please complete all applicable areas on this page and e-mail to R-SupplierRequest@orlandohealth.com

Does your company fit under any of the following vendor classifications? YES NO

**(If you check yes, please provide a copy of each certificate).*

SBE - Small Business Enterprise

MBE - Minority Business Enterprise

Other: *(Please list)*

WBE - Women's Business Enterprise

VBE - Veteran Business Enterprise

Accrediting Agency Name:

Accreditation Number:

Expiration Date:

Please provide your business contact information below:

| | | |
|--------------------------|-------------|-----------|
| Business Name: | | |
| Contact Name: | Email: | |
| Business phone: | Cell phone: | Fax #: |
| Business street address: | | |
| Suite/Mail point: | | |
| City: | State: | Zip code: |

Please provide the following company information:

| | |
|---------------------------|-------------------------------|
| D & B DUNS Number: | Certificate of Incorporation: |
| Business website address: | Certificate of Insurance: |
| Year business started: | W-9: |
| Number of employees: | |
| Annual revenue: | |

Please answer the following and provide details:

| Questions | Yes | No | Details Please specify |
|---|-----|----|------------------------|
| Are you doing business with any Orlando Health hospitals or offices? Please list locations. | | | |
| Do you make/manufacture a product? Please list products. | | | |
| Do you distribute products? Please list the brand and products. | | | |
| Do you provide services? Please list services. | | | |
| Do you provide consulting? Please list categories of expertise. | | | |
| Is your service or product construction related? | | | |
| Do you sub-contract labor? | | | |

FOR OFFICE USE ONLY:

| Date | Category | Description | Route Request to OH CRT, HPA, or Direct Dept. with executive approval | Contract (C) or Business Associate Agreement (BAA) <small>(Circle one)</small> | Reviewers Name, Contact Info and Comments <small>(sign & date)</small> | Final outcome <small>(communication with supplier - OH rep. sign & date)</small> |
|------|----------|-------------|---|---|---|---|
| | | | | RFI RFQ RFP N/A | | |

Category= CAP-Capital, CSC-Distribution Consolidated Service Center, PR-Product, SE-Service, PH-Pharmacy, L-Lab, S-Surgery, NS-Nursing Supplies, and PP-Physician Practice.