



This box for MH Use Only

VENDOR DATA SHEET

REQUIRED MH Vice President signature: _____

Company Name: _____

Order Address: _____

City: _____ State: _____ Zip Code: _____

Customer Service Information: Contact _____

Phone: _____ Fax: _____

****Does your ordering system support EDI orders? Yes No**

****Does your ordering system support EDI invoicing? Yes No**

Remit Address: _____

City: _____ State: _____ Zip Code: _____

Returns Address: _____

City: _____ State: _____ Zip Code: _____

Shipping/Incoming Terms: FOB _____

Payment Terms: _____

Normal Delivery Time: _____

Local Representative: Contact _____

Street: _____ Phone: _____

City: _____ State: _____ Fax: _____

Zip Code: _____ Voice Mail/ Pager: _____

Company Officers & Staff: Marketing or Regional Manager: _____

Phone: _____ Fax: _____

Type of Business (check one):



Methodist Healthcare Materials Management / Purchasing

Crews Wing Suite 702,
1265 Union Avenue, Memphis, TN 38104
(A Private Not For Profit Organization)

Manufacturer: ___ Stocking Distributor: ___ Manufacturer's Representative: ___

Contractor: ___ Consulting: ___ Other (Please specify): _____

Type of Business Organization:

Corporation: ___ LLC: ___ Partnership: ___ LP: ___ PA: ___ Individual: ___

General Information:

Date Organized: _____ No. of employees: _____

Location(s) of Facilities: _____

Inspected by (circle Y or N): Local Agency? Y / N State Agency? Y / N Federal Agency? Y / N

List FDA# if appropriate: _____ **Please list other inspecting authorities** ↓:

List 2 (two) Business References (Customers):

Company Name: _____ Company Name: _____

Contact Person: _____ Contact Person: _____

Phone number: _____ Phone number: _____

Address: _____ Address: _____

City: _____ State: ___ Zip: _____ City: _____ State: ___ Zip: _____

List 2 (two) Business References (Your Vendors):

Company Name: _____ Company Name: _____

Contact Person: _____ Contact Person: _____

Phone number: _____ Phone number: _____

Address: _____ Address: _____

City: _____ State: ___ Zip: _____ City: _____ State: ___ Zip: _____

Products or Services Provided (check (✓) one or more as necessary):

- ___ Medical / Surgical ___ Laboratory ___ Radiology ___ Pharmacy ___ Dietary
- ___ Physical Therapy ___ Respiratory Therapy ___ Laundry ___ Housekeeping
- ___ Maintenance ___ Other (list): _____

Construction / Building Trades:



Methodist Healthcare Materials Management / Purchasing

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Methodist does bid as required for construction and renovation projects. Please check (✓) the services the services you can supply - ___ Drywall ___ Plaster ___ Painting ___ Electrical ___ Plumbing ___ Tile/Carpet ___ Other(s): _____

General Contractor (provide TN License # →) _____

Medicare Warranties (insert name of your firm in blanks below).

It is the policy of Methodist Healthcare ("MH") and its subsidiaries not to contract or have business relationships with individuals or entities that have been excluded from federal healthcare programs by the U.S. Department of Health and Human Services Office of Inspector General, and to routinely verify that an individual or entity with which it contracts or does business has not been excluded from federal healthcare programs. _____ hereby agrees that if it is excluded from participation in federal healthcare programs, it will immediately notify MH in writing of such exclusion. _____ agrees that it has an affirmative obligation to verify whether any of its employees or subcontractors have been excluded from federal healthcare programs and warrants that it will routinely verify their status and will immediately notify MH in writing if it determines that any of its employees or subcontractors have been excluded from federal healthcare programs. _____ agrees that if MH learns that _____ or any employee or subcontractor of _____ has been excluded from participation in federal healthcare programs, MH may immediately terminate, without penalty, any contracts or other business arrangements it has with _____ upon written notice to _____.

Proof of Insurance (prior to order for product or service):

Methodist Healthcare requires that a "Certificate of Insurance" be provided to the Materials Management / Purchasing Office. The document must be an original provided to Methodist Healthcare by your insurance carrier. A minimum general liability coverage of one million dollars per occurrence with an annual aggregate of three million dollars coverage is required. Companies providing services to the Hospitals must also show Worker's Compensation and Automotive coverage. See page 6 for the required indemnity agreement, and insurance requirements of Methodist Healthcare. Complete and return with Vendor Data Sheets.



Minority Vendor(s):

Definition: A LOCAL SMALL BUSINESS is defined as a business located in Shelby County and owned at least 51% by Shelby County Residents whose gross annual sales are less than THREE MILLION (3,000,000) DOLLARS.

A MINORITY BUSINESS is defined as a business at least 51% of which is beneficially owned and controlled by minority group members. As further defined for these purposes, minority group members would be African-Americans, Women, Hispanic-Americans, Native Americans, Asian Pacific Americans, and / or Asian Indian American.

Check (✓) all the appropriate groups below:

- Local Small Business Female Owned Business African American
- Hispanic American Native American Asian Pacific American
- Asian Indian American

Group Purchasing Contracts:

Methodist Healthcare is a member of the Premier Group Purchasing and Methodist Healthcare does support Premier contracts. Check box if you currently have a relationship with our GPO.

Premier Please list any current contracts your company has with Premier:

Prepared By - Name (print) and Title:

Signature and Date:

By signing above, it is affirmed that applicant company has received and understands the Methodist Healthcare Purchasing Terms and Conditions.

Attachment:

Agreement Regarding Insurance and Indemnification

For the following, see www.methodisthealth.org, About Us, Vendor Information:

Methodist Healthcare Purchasing Terms and Conditions



Methodist Healthcare Materials Management / Purchasing

Crews Wing Suite 702,
1265 Union Avenue, Memphis, TN 38104
(A Private Not For Profit Organization)

Methodist Healthcare Facility/Entity Listing

Methodist Healthcare Credit Information

Tennessee Department Of Revenue Certificate of Exemption (All Facilities)

FOR METHODIST HEALTHCARE USE ONLY

MH Associate: _____ DATA SHEET (date received):

CERTIFICATE OF INSURANCE: _____ VENDOR NUMBER: _____ Date completed: _____



AGREEMENT REGARDING INSURANCE AND INDEMNIFICATION

Name of Vendor: _____ ("VENDOR")

A. Insurance and Indemnification:

VENDOR agrees to have and maintain at all times: (a) Commercial General Liability Insurance, and, if goods or merchandise are being sold by a manufacturer or a distributor, if said distributor modifies the goods or merchandise, to HOSPITAL hereunder, Product Liability insurance, in the minimum amounts of \$1,000,000 per occurrence, with contractual liability endorsement, (b) statutory worker's compensation insurance, and (c) automobile liability coverage for all owned or leased vehicles with minimum coverage of \$250,000 per person, \$500,000 per occurrence (required only if vehicles are to be operated by VENDOR on HOSPITAL's premises during the contract term), all of the above with a carrier or carriers qualified to do business in the state of HOSPITAL's location. VENDOR shall provide certificates of such coverage to HOSPITAL within five (5) days of execution of this Agreement. VENDOR shall also provide, or require its insurer(s) to endeavor to provide, at least thirty (30) days prior written notice of any lapse, non-renewal, cancellation or material change of such coverage. HOSPITAL may terminate this Agreement immediately upon any such expiration or cancellation of coverage.

If VENDOR's insurance is of the "claims made" type, then the following additional requirement shall also apply:

The retroactive date shall be certified to be no later in time than the commencement date of the VENDOR's performance under this Agreement, and may not be adjusted or changed without written notice to and prior written approval of HOSPITAL.

If VENDOR's insurance is of the "occurrence" type, then the following additional requirements shall apply:

VENDOR shall maintain said insurance and provide certificates of such coverage, including after the full performance, termination or expiration of this Agreement, for a period representing the normal life expectancy of the goods or merchandise being provided.

All insurance certificates shall be mailed to (1) Director of Purchasing, 1265 Union Avenue, Crews Wing, Memphis, TN 38104 and (2) Insurance Manager, 1211 Union Avenue, Suite 700, Memphis, TN 38104.

VENDOR further agrees to save, defend, hold harmless, and indemnify the HOSPITAL from and against any and all third party loss, claims, suits, or damages incurred, including reasonable attorneys' fees in defending any claim or cause of action, arising from personal or bodily injury or property damage caused by the acts or omissions of VENDOR or any of its agents, servants, employees, contractors, or subcontractors, including any product defect or product failure, as to any goods and/or services provided pursuant to the agreement or purchase order to which this Exhibit is intended to apply.

These requirements shall be deemed continuing and shall survive any termination or expiration of this Agreement.

VENDOR
By: _____
Authorized Representative
Title: _____
Date: _____

PURCHASING HOSPITAL
By: _____
Authorized Representative
Title: _____
Date: _____