# VENDOR OWNERSHIP & CONFLICT OF INTEREST CERTIFICATION

Vendor: _____ Address: _____

_____

Service or Product Type(s):_____ City/State/Zip_____

_____

Organizational form: ☐ Corporation, profit ☐ Partnership ☐ Individual or Sole Proprietorship
☐ Corporation, nonprofit[+] ☐ LLC ☐ LLP ☐ Other_____

**The person, company, business or other entity named above ("Vendor") hereby certifies that the information provided by Vendor in connection with this Certification is true and accurate.**

1. Is your company a government agency? ☐ NO ☐ YES
2. Is your company an academic organization? ☐ NO ☐ YES
3. Does your company currently have a contract position with Vizient GPO? ☐ NO ☐ YES

If you answered "yes" to any of the questions above, simply sign the Vendor Certification at the end of the form and return the form to the address on the notice.

If you answered "no" to the questions above, you must complete the sections below, sign, and return the form to us. For purposes of this certification, the term "immediate family member" means the following individuals: husband or wife; natural or adoptive parent, child, or sibling; stepparent, stepchild, stepbrother, or stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law; grandparent or grandchild; and spouse of a grandparent or grandchild.

## VENDORS MUST COMPLETE ALL SECTIONS I, II, III AND IV

**SECTION I: Vendor's Ownership Type. (*Check only one box*).**

| | | |
|---|---|---|
| ☐ | **1** | Vendor is NOT owned directly or indirectly by a physician or immediate family member of a physician, and NO physician or immediate family member of a physician is known to have a direct or indirect ownership interest in a business that is an Affiliate of Vendor, OR |
| ☐ | **2** | Vendor is owned directly or indirectly by a physician or immediate family member of a physician OR a physician or immediate family member of a physician is known to have a direct or indirect ownership interest in Vendor or a business that is an Affiliate of Vendor.<br><br>***If this box is selected, Vendor must complete and submit along with this Certification the attached Vendor Physician Arrangements List.*** |

## SECTION II: Conflict of Interest

Is your company owned or governed in whole or part by a physician (or an immediate family member of a physician) who may refer or treat patients at a VVMC facility? ☐ No ☐ Yes

Does your company employ or contract with a physician (or an immediate family member of a physician) who may refer or treat patients at a VVMC healthcare facility? ☐ No ☐ Yes

Does your company have a direct or indirect ownership, or investment interest (investment interests include limited partnerships and stock options paid in exchange for consulting services) with a physician or with an immediate family member of a physician? ☐ No ☐ Yes

Is your company owned or governed in whole or part by or does it provide anything of monetary value to any person* (other than a physician or an immediate family member of a physician) who may refer patients to a VVMC facility? ☐ No ☐ Yes

***If "Yes" is selected for the immediately preceding question, please provide the name(s) and describe the particulars on a separate sheet.***

*Person includes, but is not limited to, VVMC Officers, Board Members, Department Directors, non-physician clinical providers and others in VVMC positions of comparable influence or authority.

## SECTION III: Physician Compensation Arrangement.

Does the Vendor (or an Affiliate of Vendor) have compensation arrangement(s) with a physician, immediate family member of a physician, or an entity in which a physician or an immediate family member of a physician has an ownership interest?

☐ Yes ☐ No

If Yes, Vendor must provide the following certification:

Vendor certifies that the aggregate compensation under its compensation arrangements with physicians, immediate family members of a physician, or entities in which a physician or an immediate family member of a physician has an ownership interest, is fair market value and commercially reasonable, and does NOT vary with, or take into account, the volume or value of referrals or other business generated by the physician(s) for any hospital, healthcare facility, clinic or other healthcare provider.

_____
[Initials of Authorized Vendor Representative]

## SECTION IV: Current and Future Notice by Vendor.

Vendor agrees to promptly notify VVMC at [phone_____], of any other changes to the information provided on this Certification Form as soon as such changes are known, but in no event later than thirty (30) days of the change.

Vendor understands and acknowledges that upon such notification, VVMC and its affiliated entities may immediately suspend all purchases from and payments to Vendor until the information provided by Vendor has been reviewed to ensure compliance with VVMC policies and applicable laws.

_____
Initials of Authorized Vendor Representative

## Vendor Physician Arrangements List

If Vendor selects Section I, Box 2, Vendor must complete each of the fields in the chart below with respect to any physician who (i) has a direct or indirect ownership interest in the Vendor, (ii) whose immediate family member(s) has a direct or indirect ownership interest in the Vendor, or (iii) is a member of a group practice with any physician identified in (i) or (ii). For physicians named below because an immediate family member has a direct or indirect ownership interest in the Vendor, please indicate specifically whether the immediate family member is the physician's spouse or another immediate family member.

| Name of Physician Owner | If Physician Ownership is in an Affiliate(s) of Vendor, Identify Affiliate(s) | State in which Physician is Licensed / Practicing | National Provider Identifier (NPI) | Name of Group Practice | Names of (and Tax ID/NPI) of All Other Physician Members of Physician's Group Practice | Affiliations, Privileges, or Referral Relationships with Any HCA Entity/Facility |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

***Attach additional pages as necessary***.

## VENDOR CERTIFICATION

**The Vendor hereby certifies that it is not currently excluded from, ineligible to participate in, and to the best of its knowledge it is currently not under investigation by the Officer of the Inspector General for HHS or other governmental authority which investigation could lead to it being excluded or otherwise ineligible to participate in, any Federal or State health care program, that the information provided and contained herein is true and accurate, that Vendor will promptly notify VVMC and update this Certification form in writing within thirty (30) days of any change in the information provided:**

Name of Vendor: _____

Certified by: _____

Signature: _____ Date: _____

Name: _____ Phone: _____

Title*: _____

*If not an officer of the Vendor, please attach proof of authority to sign.