

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).

<input type="checkbox"/>	1	Vendor is <u>NOT</u> owned directly or indirectly by a physician or immediate family member of a physician, and <u>NO</u> 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, <u>OR</u>
<input type="checkbox"/>	2	Vendor is owned directly or indirectly by a physician or immediate family member of a physician <u>OR</u> 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. <i>If this box is selected, Vendor must complete and submit along with this Certification the attached Vendor Physician Arrangements List.</i>

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 or ineligible to participate in any Federal or State health care programs, 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.