New Supplier Request Form

Requsted Information	Responses
Vendor Information	
Vendor Name	
Is your company registered with OHIOHEALTH through the Vendormate portal?	
Is your company a diversity vendor?	
If so, please list the diversity type (MBE, WBE, SBE, MWBE, Veteran).	
If so, please list the certification number.	
If so, please list the expiration date.	
If so please also provide a copy of your company's diversity certificate.	Attachd seperately, if applicable
Payment Information	
Are you able to accept payment by ACH?	
If so, please provide your company's ACH email address.	
Are you able to accept payment by credit card?	
Does your company require a minimum dollar value to process purchase orders?	
Does your company charge a minimum order fee or percentage?	
Does your company employ any OhioHealth associates?	
Is your company owned by, or does it have any phsyican ownership?	
OhioHealth pays on a Net 55 standard. If you cannot accept Net 55, please provide requested terms and rational.	
Please provide your remit to information:	
Address	
Address 2	
City	
State	
Zip	
Please provide your order from information:	
Address	
Address 2	
City	
State	
Zip	
Please provide your return to vendor information:	
Address	
Address 2	
City	
State	
Zip	
Contact Information	
What is your preferred PO Dispatch Method? (Email, Fax, Phone, EDI)	
Please provide customer service contact information:	
Contact Name	
Phone	
Email	
Fax	
Please provide EDI contact information:	
Contact Name	
Phone	
Email	
Fax	
Please provide accounts receiveable contact information:	
Contact Name	
Phone	
Email	
Fax	
Please provide sales rep contact information:	
Contact Name	
Phone	
Email	
Fax	
Please provide executive contact information:	
Contact Name	
Phone	
Email	
Fax	