Baptist Health South Florida

Supplier Business Profile

Date: _____

Legal Name (per W-9): _____

Doing Business As: _____

Supplier Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Tax ID Number: _____ ☐ SSN ☐ EIN _____

DUNS Number: _____ (Required for EDI submission)

Supplier Contact/Local Sales Representative: _____

Ordering Address (if different from above): _____

Phone #: _____ Fax #: _____ Cell #: _____

Email Address: _____

Website: _____

What kind of products/services are offered by your company:? _____

_____

Does your company offer reasonable health insurance options to all employees? YES: _____ NO: _____

Are you a current Baptist Health South Florida employee?: YES: _____ NO: _____

Is your company associated with Premier Group Purchasing Organization? YES: _____ NO: _____

Is your company doing business with any entity of Baptist Health South Florida? (please indicate all that apply):

__ Baptist Hospital __ South Miami Hospital __Doctor's Hospital __ Homestead Hospital __ Mariner's Hospital

__ West Kendall Hospital __Baptist Outpatient Services __ Baptist Health Medical Group

Does your company carry Business Insurance? YES: _____ NO: _____

If yes, please attach a Certificate of Insurance documenting all coverage such as: Workers Comp, General Liability, Auto Liability, and Umbrella coverage.

Remittance Address: _____

City: _____ State: _____ Zip Code: _____

Accounts Receivable Contact: _____ Phone #: _____

Email Address: _____

Is this a Lock Box? YES: ____ NO: ____ Payment Terms : _____

Do you use a Factor for payment submission? - If yes, please provide name and address below:

Name: _____ Address: _____

City: _____ State: _____ Zip Code: _____

Baptist Health Supply Chain Reviewer: _____ Date: _____

Accounts Payable Reviewer: _____ Date: _____

Please mail your invoices to:
Baptist Health South Florida
Attn: Accounts Payable
8900 North Kendall Drive
Miami, FL 33176

OR e-mail your **invoices** to:
APDEPT@BAPTISTHEALTH.NET

Baptist Health South Florida

Supplier Business References

Reference #1:

Company Name:

_____

Company Address:

_____

City: _____ State: _____ Zip Code: _____

Contact Name: _____ Phone #: _____

Email Address:

_____

Reference #2:

Company Name:

_____

Company Address:

_____

City: _____ State: _____ Zip Code: _____

Contact Name: _____ Phone #: _____

Email Address:

_____

Reference #3:

Company Name:

_____

Company Address:

_____

City: _____ State: _____ Zip Code: _____

Contact Name: _____ Phone #: _____

Email Address:

_____

Baptist Health South Florida

By signing this Supplier Business Profile, Supplier has read, understood, and agrees to adhere to all of the following:

- BHSF Confidentiality Pledge
- BHSF Code of Ethics
- BHSF Conflict of Interest
- BHSF Purchase Order Terms and Conditions
- BHSF Supplier Relations Policy/Supply Chain Policies and Procedures

Links to the above mentioned documents can be found on the Baptist Health South Florida Supplier website, under the Resources section: https://baptisthealth.net/en/ps/pages/default.aspx

Signature: _____Date: _____

Print Name: _____

Company: _____