Baptist Health South Florida

Supplier Business Profile

Date: _____

Main Information

Legal Company Name: (As stated on W9)	
Doing Business As (DBA):	
Tax ID: EIN # or SSN #	
Website:	
DUNS: (For EDI submission)	
Payment Terms:	NET45

Business Address

Corporate HQ Business Address (Street/City/State/Zip)	Payment/Remittance Address (if different from Corporate)
Purchase Order Address (if different from Corporate)	**Other Address (i.e., Factor company)**

Contact Information (To Place Orders-Sales)

Name	Title	Phone #	Fax #	Email Address

Contact Information (Corporate Management)

Name	Title	Phone #	Fax #	Email Address

Contact Information (For Billing/Payment-Accounts Receivable)

Name	Title	Phone #	Fax #	Email Address

Complete if you use Factor for payment submission.

For remittance address, complete the Business Address section under "Other Address".

Company Name	Phone #	Fax #	Email Address

Supplier General Information

What kind of products/services are offered by your company?		
Has your company previously done business with any of our BHSF entities? If so, please indicate which ones and in what capacity.		
Is your company related to another company? (i.e. Parent or Sister Company). If so, please provide the name and Tax ID #.		
Are you a current BHSF employee? If yes, please contact Audit & Compliance at ContactCompliance@BaptistHealth.net.	YES	NO
Have you ever been a BHSF employee? If yes, please indicate when and for how long.		
Does your company offer reasonable health insurance to employees?	YES	NO
Is your company associated with Premier Group Purchasing Organization?	YES	NO
Does your company carry Business Insurance? If yes, please attach a COI. (Workers Comp, General Liability, Auto Liability, etc.)	YES	NO

BHSF accepts invoice submission via the following methods. Circle the one that your company will use to bill us.

Via Email: APInvoices@BaptistHealth.net (PDF Format, One invoice per email.)	YES	NO
Via EDI (Electronic Data Interchange)	YES	NO

BHSF provides the following payment methods. Circle the one that your company prefers to receive our payments.

ePayables Credit Card (Bank of America–Virtual Card)	YES	NO
Paymode–X ACH (Third Party Affiliate)	YES	NO

If you cannot accommodate any of the above (invoice submission or payment method), please contact our Accounts Payable Department at the AP Customer Service email address: APDept@baptisthealth.net.

A Purchase Order number must be reflected on the invoices to avoid delay in payments.

Please check (✓) the Type of Contractor that applies:

	Domestic Contractor Outside US		JWOD Nonprofit Agency
	Educational Institution		Large Business
	Foreign Contractor		Minority Institution
	Hospital		Nonprofit Organization
	JWOD Nonprofit Agency		Small Disadvantaged Business
	Other Small Business		

Please check (✓) the SDB Program (Small Disadvantaged Business) that applies:

	8(a) Contract Award		SDB Participating Program
	8(a) With HUBZone Priority		SDB Price Evaluation Adjust
	Not Applicable		SDB Set−Aside

Please check (✓) other Preference program that applies:

	Buy Indian		Small Business Set−Aside
	Directed to JWOD Nonprofit		Very Small Business Set−Aside
	No Preference/Not Listed		

Please check (✓) Ethnicity that applies:

	African American		Native American
	Asian American		Other
	Hispanic American		

Please check (✓) HUBZONE Program that applies:

	Combined HUBZone Price Adjust		HUBZone Sole Source
	HUBZone Price Evaluation Preference		Not Applicable
	HUBZone Set−Aside		

Please check (✓) Size of Small Business that applies:

	50 or less		51 − 100
	101 − 500		501 − 1000
	1001 − 1500		1,500 +

Please check (✓) VOSB - Veteran Owned Small Business that applies:

	Not Veteran Owned Small Business		Service Disabled VOSB
	Other Veteran Owned Small Business		

Please check (✓) any category that your company identifies with:

	Emerging Small Business		Veteran
	Women Owned Business		Disabled
	LGBTQ+ Owned Business		

Supplier Business References:

Reference # 1:

Company Name	Corporate HQ Business Address (Street/City/State/Zip)
Contact Name	Contact Phone #/ Email address

Reference # 2:

Company Name	Corporate HQ Business Address (Street/City/State/Zip)
Contact Name	Contact Phone #/ Email address

Reference # 3:

Company Name	Corporate HQ Business Address (Street/City/State/Zip)
Contact Name	Contact Phone #/ Email address

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

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

Links to the above mentioned documents can be found on the Baptist Health South Florida Supplier website, https://baptisthealth.net/healthcare-professionals/for-vendors.

_____	_____
Signature of Company Representative	Company Name
_____	_____
Print Name	Date

Pledge to protect patient confidentiality

When you are in any of our Baptist Health South Florida facilities assisting us in the use of your devices or when you collect information from us or our patients regarding an FDA–regulated device for which you have responsibility, your actions must be consistent with the privacy of our patients. These expectations arise under the policies and procedures that we have established to implement the federal privacy regulations and applicable state laws. To help ensure that our expectations in regards to our patients privacy are met, by signing below you agree to:

- Notify our personnel when registering, signing in, or visiting our premises, in accordance with our established procedures.
- Obtain, use and disclose protected health information ONLY as necessary to assist us or a patient using your device or to fulfill your obligations under the Federal Food Drug and Cosmetic Act.
- Seek clarification from the Baptist Health Chief Privacy Officer at 786–596–8850 if you have any questions about whether you may obtain, use or disclose protected health information.
- Guard and maintain the confidentiality of protected health information, including, but not limited to, keeping such information secure, private, and out of public view, and avoiding conversations about such information except as necessary to meet your obligations.
- At a minimum, by executing this pledge, you are agreeing to not record, use, or disclosure any protected health information to which you are incidentally exposed to on our premises without permission.
- Immediately report to the Baptist Health Chief Privacy Officer any uses and/or disclosure that do not comply with applicable law or these confidentiality requirements or any breach or threat to the security of protected health information of which you become aware.

If you have any questions with respect to our expectations or policies, please contact the Baptist Health Chief Privacy Officer at 786–596–8850 or Baptist Health Supply Chain Services at 786–596–6565.

I attest to having read the above pledge and agree to comply with the expectations set forth with the above confidentiality requirements to assist Baptist Health South Florida in protecting health information regarding their patients.

_____ _____

Signature of Company Representative Company Name

_____ _____

Print Name Date

Conflict of Interest

The company completing the supplier package certifies that no officer, executive or director of Baptist Health South Florida or its affiliates has received or will receive within twelve (12) months, any compensation, grant, award or item of value in excess of $ 300.00 in connection with the award of any contract, except as fully disclosed by attachment. Furthermore, the company signing this form certifies that no officer of the company holds a position on the Board of Directors of Baptist Health South Florida, Board of Directors of any Baptist Health South Florida affiliate or serves as an employee of Baptist Health South Florida or any of its affiliates.

_____	_____
Signature of Company Representative	Company Name
_____	_____
Print Name	Date