UC Davis Medical Center New Vendor Information

All of the below required documents need to be received before the vendor request can be processed.

Before you submit a request for a new vendor, please check that you have attached and done the following:

__ A signed Business Information Form (BIF) that includes your UC Davis Med Center contact (this is the UC Davis Employee that is wanting to purchase goods or services from your company). If you do not have a UCD contact, please call (916)734-2475 to get a contact person. REQUESTS CANNOT BE PROCESSED WITHOUT A UCD CONTACT.

__ A signed copy of your W9. (Note: checks can only be made out to the business names listed on the W9). If your Tax ID # on your W9 changes at any time a new vendor record will need to be created and all new documentation will be needed.

__ A certificate of insurance naming The Regents (see below):

The Regents of the University of California
1111 Franklin Ave
Oakland, CA 94607

If you have questions about insurance requirements or would like to request a waiver for insurance please contact
Mark Vanderlinden mvanderlinden@ucdavis.edu

__ Send all documents as PDF attachements to hs-vendormaintenance@ucdavis.edu, cc'ing your UCD Med Center contact. In the subject line note the name of the company [ex: ABC Company - New Vendor Request].

Electronic Funds Transfer Sign-up

UC Davis Health offers FREE electronic funds transfer (EFT) to help you receive funds quicker. To sign-up for EFT, please fill out the following EFT Authorization sign-up form and send it to hs-vendormaintenance@ucdavis.edu. Be sure to include one form of back-up documentation: a blank voided check* or a bank reference letter*.

Please note:
- If your banking information does not match your check, DO NOT use this form of back-up.
- A bank reference letter is on bank letterhead and includes banking information stated on your enrollment form and is signed by a representative of the bank.

__ I have included my completed EFT form AND attached a blank voided check OR a reference letter.

UCDAVIS HEALTH | MEDICAL CENTER

Email Completed Form to Vendor Maintenance: hs-vendormaintenance@ucdavis.edu

UC Davis Medical Center Business Information Form

To be completed by ALL FORMS OR INDIVIDUALS PROPOSING TO BECOME A SUPPLIER OF GOODS OR SERVICES TO THE UNIVERSITY OF CALIFORNIA, DAVIS MEDICAL CENTER

This form must be accompanied by a **signed W-9 (US)** or **W-8 (foreign)** form with a **typed taxpayer identification number** and a **valid general liability insurance certificate** in order to be added to our vendor database.

SUPPLIER INFORMATION

LEGAL NAME (as registered with the IRS)	**PARENT COMPANY NAME (if applicable)**
BUSINESS NAME/DBA (if different than above)	**COUNTRY** (if not USA)

PURCHASE ORDER ADDRESS (number, street, and apt or suite no., city, state and postal code)

PURCHASE ORDER PHONE NUMBER	**PURCHASE ORDER FAX NUMBER**	**PURCHASE ORDER EMAIL**

REMITTANCE ADDRESS (number, street, apt or suite no., city, state and postal code)

ACCOUNTS RECEIVABLE PHONE #	**PAYMENT TERMS**	**ACCOUNTS RECEIVABLE EMAIL**
CONTACT NAME (Order and Remit)		**WEBSITE** (URL)
UCD Med Center CONTACT NAME ó¦/59at[h¸99ú		**UCD Med Center CONTACT EMAIL (UCD EMPLOYEE)**

DESCRIPTION OF PRODUCTS OR SERVICES BEING PROVIDED (ATTACH SALES LITERATURE AS APPROPRIATE)

IS SERVICE BEING DONE IN CALIFORNIA ?

YES ◯ NO ◉

Please indicate if any of the owners have any of the following relationships with the University of California, Davis:

UCD EMPLOYEE: Yes ◯ No ◯ **UCD RETIREE:** Yes ◯ No ◯

RELATIVE OF UCD EMPLOYEE: Yes ◯ No ◯

PERSONS AUTHORIZED TO COMMIT YOUR FIRM TO A CONTRACT:

Name: **Title:**

Name: **Title:**

Name: **Title:**

INSURANCE REQUIREMENTS

The University selects insurance requirements based on degree of risk, rather than the dollar value of the contract. All Insurance policies required shall be subject to review and approval by the University and the holder must be named as: The Regents of the University of California, 1111 Franklin Ave, Oakland CA 94607.

BUSINESS TYPE/CERTIFICATIONS

BUSINESS TYPE:

☐ **LARGE BUSINESS ENTERPRISE** ☐ **EDUCATIONAL**

☐ **FOREIGN** ☐ **NONPROFIT ORGANIZATION**

FEDERAL CERTIFICATIONS: Self-certify with the Federal Government

☐ **SDB** (Small Disadvantaged Business) ☐ **VOSB** (Veteran Owned Small Business) ☐ **MBE** (Minority Business Enterprise)

☐ **Hub Zone** (Historically Under-Utilized Small Business ☐ **VBE** (Veteran Owned Business) ☐ **HBCU/MI** (Historically Black College or Minority Institution)

☐ **ANC** (Alaska Native Corporation) ☐ **SDVOSB** (Service Disabled Veteran Owned Small Business ☐ **WOSB** (Woman Owned Small Business)

STATE OF CALIFORNIA CERTIFICATIONS: Self-certify on the State of CA website

☐ **WBE** (Woman Business Enterprise) ☐ **SBE** (Small Business Enterprise) ☐ **DBE** (Disadvantaged Business Enterprise)

☐ **DVBE** (Disabled Veteran Business Enterprise

ABILITY ONE PROGRAM: (75% of total direct labor hours must be performed by people who are blind or have other significant disabilities)

☐ **Ability One**

CERTIFICATION

I hereby certify under penalty of perjury under the laws of the State of California that I have read this application and know the contents thereof, and that the business category and ethnicity indicated above reflect the true and correct status of the business in accordance with Federal Small Business Administration criteria and Federal Acquisition Regulations, FAR 19, pertaining to small, disadvantaged, woman, disabled veteran, small and disadvantaged, and small and woman-owned business enterprises. I understand that falsely certifying the status of this business, obstructing, impeding or otherwise inhibiting any University of California official who is attempting to verify the information on this form may result in suspension from participation in University of California business contracts for a period up to 5 years and the imposition of any civil penalties allowed by law. In addition, I understand that this business must notify the University of California in writing 30 days in advance of any changes in size, ownership, control, or operation which may affect this business's continued eligibility as a SBE, DBE, WBE, DVBE, SWBE or SDVBE.

SIGNATURE	**DATE**
PRINTED NAME	**TITLE**

Send correspondence to:

Invoices:

- **Email to:** hs-ucdhsap@ucdavis.edu
- **Mail to:**

UC DAVIS MEDICAL CENTER
PO BOX 168016
SACRAMENTO, CA 95816-8016

Capital Invoices:

Email to: hs-capitalfinance@ucdavis.com
Mail to:

UC DAVIS MEDICAL CENTER
ATTN: CAPITAL FINANCE
C/O FACILITIES DESIGN & CONST
4800 2ND AVE SUITE 3010
SACRAMENTO, CA 95817

UCDAVIS HEALTH | MEDICAL CENTER

b9 ² ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION {LDb¦t

Please note: Section I MUST be completed in its entirety.

Section I

All information in Sections I & II must be typed

Business Name: _____

Remittance Address: _____

Remittance Email: _____

Phone Number: _____

Fed Tax ID: _____

Tax ID or SSN must match the number on the W9 provided.

Or
SSN (last four digits only): XXX-XX-_____

Section II ¦{9 hb9 Chwa t9w . !bY ! / / h ¦b¢

Bank Name: _____

Address: _____

_____

Bank Routing # _____

Account Number: _____

◉ Checking ○ Savings

_____ _____
Authorized Signature Date

_____ _____
Print Name Title

You are required to submit ONE of the following with this completed EFT Form:

◉ Copy of blank voided check (if your banking info does not match your checks, send a reference letter)

○ Reference Letter from your financial institution (on institution letterhead, with banking info stated and signed by a representative of the bank.)

Send this completed form with required supporting documentation to:

Email to: HS-VendorMaintenance@ucdavis.edu

- This authorization will remain in effect until cancelled in writing. Failure to notify Vendor Maintenance of a closed account will cause a delay in receiving your payments.
- Please notify Vendor Maintenance of any changes.