VENDOR/ SALES REPRESENTATIVE REGISTRATION FORM

COMPANY_____
NAME _____
POSITION/TITLE _____
MAILING ADDRESS_____
_____
_____

CONTACT INFORMATION:
BUSINESS PHONE _____ _____
CELL PHONE _____ _____
PAGER _____ _____
FAX _____ _____
EMAIL ADDRESS _____
COMPANY WEBSITE _____

REPORTS TO/MANAGED BY:
NAME _____
POSITION/TITLE _____
MAILING ADDRESS_____
_____
_____

BUSINESS PHONE _____ _____
CELL PHONE _____ _____
PAGER _____ _____
FAX _____ _____
EMAIL ADDRESS _____

_____ _____
Signature Date

Signature affirms the individual has received, read, and understands the Methodist Healthcare Standards of Conduct, the Vendor/Sales Representative Relations Policy, the Methodist Healthcare Conflict of Interest Policy , the Methodist Healthcare Code of Ethics Policy and the applicable HIPPA Privacy Rule and agrees to abide by their terms and conditions and the instructions for Emergency Codes and Vendor Rebate Payments, as applicable.

Rev: January 2009