

Vendor, please complete pages 1 and 2.

Organization's
Legal Name:

Tax ID:

Is the Tax ID a social security #?

Yes No

Does your organization transmit orders via EDI?

D.U.N.S. Number:

Yes No

If not then provide the fax number or email your organization uses to receive orders (no individual/personal email addresses):

Is your organization certified as diverse (such as minority or women owned)?

Yes (please attach certification) No

Is your organization 1099 eligible?

Are any of your organization's agents or employees
employed by NYC Health + Hospitals Corporation?

Yes No Yes No

Account Representative
Contact Name:

Account Representative
Email:

Account Representative
Phone:

General Customer Service
Phone Number:

General Customer
Service Email:

By typing my name in the box below, I attest and affirm that the information contained herein is true and accurate to the best of my knowledge.

Completed By:

Date:

Payment Account Information (if receiving electronic payments):

ACH: Yes No

Bank Name:

Routing #:

Bank Account #:

Vendors need to provide one of the following 3 documents to have ACH payment set up:

- 1) Voided check from vendor's account
- 2) Copy of bank statement showing banking account number
- 3) Letter from the vendor's bank (with contact information) verifying the account information

Legal Business Address (Required):

Entity Name:

Street:

City/State/Zip:

Remittance Address (if different from above):

Entity Name:

Street:

City/State/Zip:

Ordering, Delivery or Return to Address (if different from above):

Entity Name:

Street:

City/State/Zip:

Address 4 (if different from above):

Address Type:

Entity Name:

Street:

City/State/Zip:

**To be completed by
NYC Health + Hospitals Staff**

Request Type: New Vendor
 Revision (Provide Vendor #)

Vendor Request
Completed By:

Signature: _____ Date: _____

Senior Business
Approval:

Signature: _____ Date: _____

ASSIGNED VENDOR #: _____