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?

◯ 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?

◯ Yes ◯ No

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

◯ 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 #:

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 #: _____