

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 attachments 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.

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 (y#) - U hQ' --		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 <input type="checkbox"/> No <input type="checkbox"/> UCD RETIREE: Yes <input type="checkbox"/> No <input type="checkbox"/>			
RELATIVE OF UCD EMPLOYEE: Yes <input type="checkbox"/> No <input type="checkbox"/>			
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**
- FOREIGN**
- EDUCATIONAL**
- NONPROFIT ORGANIZATION**

FEDERAL CERTIFICATIONS: Self-certify with the Federal Government

- SDB** (Small Disadvantaged Business)
- Hub Zone** (Historically Under-Utilized Small Business)
- ANC** (Alaska Native Corporation)
- VOSB** (Veteran Owned Small Business)
- VBE** (Veteran Owned Business)
- SDVOSB** (Service Disabled Veteran Owned Small Business)
- MBE** (Minority Business Enterprise)
- HBCU/MI** (Historically Black College or Minority Institution)
- WOSB** (Woman Owned Small Business)

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

- WBE** (Woman Business Enterprise)
- DVBE** (Disabled Veteran Business Enterprise)
- SBE** (Small Business Enterprise)
- DBE** (Disadvantaged 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:

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

VENDOR ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION FORM

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:

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

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

Section II

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.