



Supplier Diversity Registration Form

Please complete all fields

Company Information

Legal Company Name:

D/B/A Name:

Address Line 1:

Address Line 2:

City:

State:

Zip Code:

Main Phone:

Website:

Federal Tax ID:

Federal Tax Classification (Please check one below):

Individual/Sole Proprietor C Corporation S Corporation

Partnership Trust/Estate Limited Liability Company

Other:

Please select one: Publically Held Privately Held

Number of Years in Business:

Last Year's Annual Sales:

Number of Permanent Employees:

Business Classification (Select both if applicable):

- Minority Owned - at least 51 percent owned by one or more United States citizens or permanent resident aliens who are Black, Hispanic, Asian, Pacific Islander, or Native American
- Women Owned - at least 51 percent owned by one or more women

Certification:

- | | |
|---|----------------|
| <input type="checkbox"/> National Minority Supplier Development Council (NMSDC) | Expires: _____ |
| <input type="checkbox"/> Women's Business Enterprise National Council (WBENC) | Expires: _____ |
| <input type="checkbox"/> National Women Business Owners Corporation (NWBOC) | Expires: _____ |
| <input type="checkbox"/> Federal | Expires: _____ |
| <input type="checkbox"/> State | Expires: _____ |
| <input type="checkbox"/> Local | Expires: _____ |
| <input type="checkbox"/> Other: _____ | Expires: _____ |

Commodity (Select all that apply):

- | | |
|---|--|
| <input type="checkbox"/> Advertising/Marketing | <input type="checkbox"/> Office Supplies |
| <input type="checkbox"/> Building/Construction | <input type="checkbox"/> Paging Equipment |
| <input type="checkbox"/> Collection Services | <input type="checkbox"/> Pharmacy |
| <input type="checkbox"/> Computer Hardware | <input type="checkbox"/> Printing |
| <input type="checkbox"/> Consulting/Professional Services | <input type="checkbox"/> Product Development |
| <input type="checkbox"/> Durable Medical Equipment | <input type="checkbox"/> Promotional Merchandise |
| <input type="checkbox"/> Environmental | <input type="checkbox"/> Provider |
| <input type="checkbox"/> Facilities | <input type="checkbox"/> Real Estate |
| <input type="checkbox"/> Graphic Design | <input type="checkbox"/> Temporary Labor |
| <input type="checkbox"/> Home Health Aides | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Legal | |

Principal Owner Information

First Name:

Middle Name:

Last Name:

Email Address:

Phone number:

Fax Number:

Job Title:

Mailing Address: Same as company address or

Address Line 1:

Address Line 2:

City:

State:

Zip:

Contact Information

First Name:

Last Name:

Email Address:

Phone number:

Fax Number:

Job Title:

By sending this application, you certify that the information you have provided above is true and accurate.

Return completed application, proof of certification and W-9 Form to:

Email Address: supplierdiversity@vnshealth.org