Vendor Liaison Office
UW Hospital and Clinics
G5/140, M/C 1639
600 Highland Avenue
Madison, WI 53792

VLO@uwhealth.org
http://www.uwhealth.org/vendors

Phone: 608-890-8505
Fax: 608-890-8507

VENDOR REPRESENTATIVE REGISTRATION FORM

Application Date____/____/____

REPRESENTATIVE INFORMATION

Name _____

Title _____

Preferred Mailing Address _____

City, State, Zip _____

Work Phone #_____Mobile Phone # _____

E-mail _____

REPRESENTATIVE'S IMMEDIATE SUPERVISOR

Name _____

Title _____

Preferred Mailing Address _____

City, State, Zip _____

Work Phone #_____Mobile Phone # _____

E-mail _____

COMPANY

Name of Company _____

Headquarters Address _____

City, State, Zip _____

Company Main Phone # _____

Company Web Address _____

Products Represented	Vouchers for Drugs (Yes/No)

DO YOU REQUEST PATIENT AREA PRIVILEGES?

☐ Yes ☐ No

While we prohibit vendor representatives from all patient care areas or from areas where there is access to patient information, certain activities or demonstrations may warrant an exemption to this policy. Explain your request for patient contact below.

_____

_____

_____

_____

_____

_____

Date completed UW Health Safety and Infection Control training (attach certificate)___/____/____

Provide verification of a Criminal Background Check within the last two years____/____/____

Provide verification of a Caregiver Background Check_____/___/___

You will also need to provide documentation of, or immunity to, the following (include dates received and **attach documentation**):

Tuberculosis Status_____/____/____

- A TB test is required within the last twelve months, unless it is known that you are tuberculin positive. Tuberculin positive individuals must provide proof that you are not infectious.
- Any person who may potentially be exposed to a patient with suspect or active tuberculosis must be fit-tested for an N-95 respirator.

Influenza Vaccine_____/____/____

- Influenza vaccine is an annual immunization (Required OCT-MARCH)

Hepatitis B
Documentation of three doses OR a positive titer

- May be declined. If you decline hepatitis B vaccination, you will need to print a copy of the declination form from the VLO website.

Measles, Mumps, and Rubella
Two Doses of a MMR Vaccine _____/____/____,_____/____/____
OR
Positive Titer for Measles, Mumps, and Rubella ____/____/_____

Chickenpox (Varicella)
Positive Varicella Titer ____/____/____
OR
Two Doses of Varicella Vaccine __/__/__,__/__/__

*Disease history does **NOT** satisfy the requirements

DO YOU REQUEST SCRUBS?

☐ Yes ☐ No

Request Size: Top____ Bottom____
Location: _____

Explain your request for scrubs below.

_____

_____

_____

_____

_____

For Office Use Only:

Representative Scrub PIN_____Scrub Size _____

Date Scrub Fee Paid____/____/____

NOTICE REGARDING REGISTRATION FEE

All vendor personnel that conduct business with UW Health are required to pay the registration fee, except for those involved exclusively in research or product service, the supervisor listed above if visiting UWHealth less than four times per year, those vendors visiting solely in an educational or clinical role, and vendor personnel involved in negotiating rebate agreements for pharmaceuticals with UW Health personnel on behalf of Unity Health Insurance, as outlined in Policy 11.19.