



## Request for New Supplier

Return completed form and W-9 to your assigned Buyer,  
Fax copies to 513-636-3453, or Email:Purchasing@CCHMC.org

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**This form is to be completed by Department that is requesting addition of a new supplier. The form must be submitted with a completed W-9 for the supplier. (required\*)**

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Corporate Name (as shown on tax return)

Address for payment (number, street, or suite no,)

City, State, and Zip code

Business Phone Number:

Fax Number:

Sales Contact E-mail Address:

Phone:

Accounts Receivables Contact Email Address:

A/R First Name:

A/R Last Name:

A/R Phone:

A/R Fax Number:

### Item Description or Service (wanting to purchase)

Will this item be used in Patient Care?

Manufacturer:

Model No./ SKU No.

How often will the requester be ordering from this supplier?

Will you use this supplier more than 3 times in a year?

Requester Name/ Ext. Number

Title/Department

Request Date:

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### To be completed by Purchasing Department- Buyer

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Does this supplier accept purchase orders?

Min. Order Quantity

Unit of Measure

Price

Is this item available at another supplier?

If yes, explain why we should order from this supplier:

Contract Agent approved request?

Contract Agent Name:

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