New Supplier Application

General Information

Business Name: ______________________________

Address: ______________________________

Street Address

____

City *State* *ZIP Code*

Phone: ____________________ FAX Number: ____________________

General Email ______________________________

SSN or Tax Id Number: ______________________________

DUNS Number: ____________________ Website: ____________________

Supplier Type (Check all that apply):

☐ Government Agency ☐ Construction ☐ Distributor ☐ Manufacturer

☐ Non-Profit ☐ Retailer ☐ Other: ____________________

Federal Tax Classification (W-9 Must be attached):

☐ Sole Proprietor ☐ Corporation ☐ Partnership ☐ LLC

Does any LBH affiliated Physician/Employee serve as a Consultant for this Business:

☐ Yes ☐ No

Are your products for Patient Use:

☐ Patient Care Products ☐ Implantable Products ☐ Patient Care Equipment ☐ No

Remit Information

Remit Address: ______________________________

A/R Contact Name: ____________________ Phone: ____________________

Email: ______________________________

Payment Terms ☐ Net 10 ☐ Net 15 ☐ Net 30 ☐ Other: ____________________

Minority Business Enterprise Certification

To verify please attach your Current MBE certification (Check all that apply)

☐ Women Owned ☐ Small Business ☐ Minority Owned ☐ NA ☐ Other: ____________________

Certification

Under penalties for perjury, I certify that the information shown on this form is accurate.

Print Name	Title
Signature	Date

Internal use only:

Completed By: ______________________________ Date: ____________________