



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 submit 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

COVID 19 Vaccination

One dose ____/____/____

Two doses ____/____/____

Booster ____/____/____

*Booster mandatory as of 5/2/2022

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.