Palos Community Hospital

Vendor Representative Badging

Receipt of ID Badge & Acknowledgement of Receipt of the *Vendor /Hospital Relationship Guide*

Name_____ Date_____
Company_____
Address: _____ City_____ State_____Zip_____
Telephone #_____ Cell #_____
Supervisor/Manager:
Name_____
Title_____Telephone#_____

Acknowledgment/Agreement

I understand that by signing this form I am able to provide to Palos Community Hospital, upon request, current documentation, where applicable, of completion of the following:

- HIPPA training
- OSHA training
- Annual immunization verification.
- Sterile field training.

I have been issued a vendor representative identification badge by Palos Community Hospital. I understand that this identification badge must be worn in a clearly visible location at all times while in the hospital. I understand that it is the property of Palos Community Hospital and must be returned to the Public Safety Department upon transfer or termination.

I acknowledge receipt of the *Vendor/Hospital Relationship Guide* which includes the vendor code of conduct. I agree to abide by the rules set forth in this document. I understand that entrance of supplies, equipment and/or technology into Palos Community Hospital without proper authorization/approval will be considered a no-cost contribution to the hospital. I also understand that at any time my identification badge may be revoked at which time I must immediately return the badge to the Public Safety Department. I understand that a badge will be issued for 1 calendar year and must be renewed annually prior to December 31st for entrance into the institution, operating room or procedural area.

Signature_____ Date_____

Supervisor Request for Badging:

I request that the above named vendor be provided a vendor badge after completion of the information above.

Name_____ Date_____