Your product(s) are important to us. Please provide the following information and all required collateral material with new product submissions.

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| **Company Name:**  Address:  Address:  Address: | **General Company Information**  Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Website: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Vendor information**  **(new vendors only)**  **NOTE: A completed W-9 Form is required by the Patterson A.P. department before any payments can be submitted to approved new U.S. based vendors. For approved new vendors based outside of the U.S., a completed W-8BEN or W-8BEN-E Form is required.** | | |
| **Contacts: (Name, Title)** | **Contacts: (Phone, Email Address)** |
| Primary Business: | Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Primary Marketing: | Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Primary Regulatory: | Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Other Contact(s) | Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| How many years has this Company been in business? | What is your Price Increase Notification Policy? |
| Product Liability Insurance certificate; Must provide evidence of coverage via Broad Form Vendors Endorsement showing coverage for Patterson Companies, Inc. with minimum $1 million/per occurrence:  Does your company currently carry the required product liability insurance?  \_\_\_ Yes \_\_\_ No*.*  *Please Note: This is required only if Patterson decides to distribute your product.* | Are any of your products or services sold by other Patterson Companies subsidiaries?  \_\_\_ Yes \_\_\_ No  If Yes, please identify which: |
| How are you currently distributing your products?  \_\_\_ Dealer  \_\_\_ Direct  \_\_\_ Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Does company have field sales representation? **\_\_\_ Yes\* \_\_\_ No**  \*If yes, what type of field sales representation:  \_\_\_ Dedicated \_\_\_ Independent \_\_\_ Both |
| Is your company ISO 13485 Certified with MDSAP Designation? Please attach copies of all relevant ISO certifications.  \_\_\_ Yes \_\_\_ No \_\_\_ N/A | Is your company registered with the FDA?  \_\_\_ Yes \_\_\_ No  Please provide applicable registration numbers. |
| Are your products sold outside of the U.S. & Canada?  \_\_\_ Yes \_\_\_ No | Does company support EDI process:    \_\_\_ Yes \_\_\_ No |
| Payment terms: | Payment Options:  \_\_\_ Credit Card (PCN) \_\_\_ EDI \_\_\_ ACH |
| Freight Terms (FOB): | Order/Weight Minimums: |
| Pursuant to the Patient Protection and Affordable Care Act, we are obligated to report payments made by our Company to “Physicians”. For more information on the Sunshine Act and similar state laws, please refer to:  • National Physician Payment Transparency Program Open Payments website has several resources for physicians and teaching hospitals to learn more about the Sunshine Act, including Frequently Asked Questions.  • The American Dental Association has posted FAQ’s available to its members.  • American Medical Association website also has information for physicians, including a downloadable brochure.  In order to fulfill our responsibilities under this law and related regulations, please provide the following information:  1. Are you a public company?  2. If not, are you “Physician-owned”, meaning owned either entirely or partially by a medical doctor, doctor of osteopathy, dentist, podiatrist or chiropractor?  3. If you are Physician owned, please provide the names and relative ownership of the Physicians, along with National Provider Identifier number(s). (Attach a separate sheet if necessary).  NAME OWNERSHIP NPI NUMBER  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Please indicate all of the following that apply to this business entity\*:  \_\_\_ Business qualifies as a small business  \_\_\_ Business qualifies as a small disadvantaged business  \_\_\_ Business qualifies as a small woman-owned business  \_\_\_ Business qualifies as a HUBZone business  \_\_\_ Business qualifies as a veteran-owned small business  \_\_\_ Business qualifies as a service-disabled, veteran-owned small business | | |
| **Product & Marketing Information** | | |
| **What type of products or services do you offer?** | | |
| **What marketing activities are planned for your product(s)?**  (i.e., trade journal ads, distributor ads, etc.) | | |
| **Are marketing co-op advertising funds available for advertising? \_\_\_ Yes \_\_\_ No** | | |
| **Additional comments:** | | |
| ***Supplier acknowledges Patterson’s Supplier Code of Conduct (***[***http://www.pattersoncompanies.com/CodeOfConduct***](http://www.pattersoncompanies.com/CodeOfConduct)***) and certifies it will operate in accordance with the standards contained therein. Further, Supplier has not been excluded by the federal government from participation in any governmental program nor, to the best of its knowledge, have it been proposed for exclusion; it agrees to notify the Patterson immediately upon receipt of written or verbal notification that Supplier is proposed for exclusion from any governmental health program.*** | | |
| **Submitted by: \_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_**  **Phone number: \_\_\_\_\_\_\_\_\_\_\_**  **Email address: \_\_\_\_\_\_\_\_\_\_\_** | | |
| **PATTERSON MARKETING & REGULATORY INFORMATION for PRIVATE LABEL** | | |
| *Required documents for Private Label Vendors. Return completed form to the distribution list:* [*Dental - Regulatory Owners*](mailto:Dental-RegulatoryOwners@pattersoncompanies.com)    \_\_\_ Product liability insurance certificate  \_\_\_ W9 Form Received. (U.S. Vendors only)  \_\_\_ W-8BEN/W-8BEN-E Form Received. (Vendors based outside of the U.S. only)  \_\_\_ Evidence of a Quality Management System  (Quality Manual, FDA EIR, ISO 9001 or ISO 1345 certificate)  \_\_\_ Proof of US FDA Establishment Registration  \_\_\_ Completed QA-01 Private Label Quality Agreement | | |

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| PATTERSON DENTAL APPROVAL TO ADD NEW PRIVATE LABEL VENDOR | |
| Signed by | Merchandise Marketing |
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| Signed by | Regulatory |
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