

HCA VENDOR OWNERSHIP CERTIFICATION

Vendor: _____ Address: _____

Service or Product Type(s): _____ City/State/Zip _____

Organizational form: Corporation, profit Partnership Individual or Sole Proprietorship
 Corporation, non profit LLC LLP Other _____

The person, company, business or other entity named above ("Vendor") hereby certifies that the selection made below is true and accurate:

SECTION I: Organization's Ownership Type. (check only one box).

1	Supplier is a publicly held company with less than \$75 million dollars in stockholder's equity or is not traded on an exchange, and no physician nor an immediate family ¹ member of a physician is known to have any ownership interest in Supplier.
2	Supplier is a privately held entity, and no physician or an immediate family member of a physician individually owns, directly or indirectly, any ownership interest. OR: I am an individual or sole proprietorship, and I am not a physician/medical doctor, nor do I have a physician/medical doctor in my immediate family.
3	Supplier is a publicly held company with its stock publicly traded, and stockholder's equity of at least \$75 million dollars for the last fiscal year (please attach Balance Sheet).
4	Supplier is a privately held entity, with one or more physicians- or an immediate family member of a physician- directly or indirectly having an ownership interest; or Supplier is a physician. (list names of physician owners on continuing page)
5	Supplier is a publicly traded company with less than \$75 million dollars in stockholder's equity or is not traded on an exchange , and a physician or an immediate family member(s) of a physician is known to have an ownership interest, individually or collectively, in Supplier. (list names of physician owners on Continuing Page)

If Option **4** or **5** is checked, does Vendor have a written, signed contract with any HCA affiliated entity? Yes No
 Contract Pending If "yes," please attach a copy to this certificate.

SECTION II (Box 7): Physician Compensation Arrangement.

Does the Vendor have a current compensation arrangement with a physician or immediate family member of a physician who refers patients, tests, or services to the HCA contracting party(ies)?
 Yes No If "YES," please list names of the referring physicians on Continuing Page.

HCA CONTACT INFORMATION (HCA or Affiliate who is sending this request-Please complete contact information below)

Name of HCA Affiliated Entity: _____
 Contact Name: _____, Title _____, Phone Number _____
 Fax completed Certificate to: _____
*****Completed form may also be faxed to 866-855-0022.**

Vendor agrees to promptly notify Supply Chain Consolidated Service Center at 245B Great Circle Road, Nashville TN 37228 of any changes in the above as soon as such changes are known.

¹ An immediate family member means husband or wife; birth or adoptive parent, child, or sibling; stepparent, stepchild, stepbrother, or stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law or sister-in-law; grandparent or grandchild; and spouse of a grandparent or grandchild.

