VENDOR REPRESENTATIVE REGISTRATION FORM

Application Date: _____ Month to Present: _____ Virtual or In-Person:_____

REPRESENTATIVE INFORMATION

Name: _____

Title: _____

Mailing Address: _____

City, State, Zip: _____

Work Phone: _____ Mobile Phone: _____

Fax: _____ E-mail: _____

COMPANY

Name of Company: _____

Address (if different than above): _____

City, State, Zip_____

Company Main Phone: _____

Company Web Address: _____

How many representatives will be present at the meeting? _____

Please make check payable to: APIC Ch. 20 and send to APIC Ch. 20 treasurer or can pay via PayPal @ _____

☐ $110 if Vendor provides lunch/snacks

☐ $210 if Vendor does not provide lunch

Latoria Taylor

110 Haylie Ct

Macon, GA 31216

Latoria.taylor@atriumhealth.org

VISITING VENDOR REPRESENTATIVE CONFIDENTIALITY AGREEMENT AND POLICY ACKNOWLEDGEMENT FORM

- Federal and state laws, accreditation standards, and professional ethics require that the institution maintains the confidentiality of patient information to the greatest extent possible. The purpose of this agreement is to establish the following

understanding between APIC Ch. 20 and the vendor representatives regarding confidentiality of patient information.

- I understand that I have been permitted to conduct business with APIC Ch. 20 and that I am allowed to discuss or request specific patient information.
- I understand that during conducting business, I may be requested to adhere to the hosting institution's vendor policies and procedures and practices.

_____ _____

Signature of Vendor Representative Date

_____ _____

Signature of APIC Ch. 20 Representative Date