Cooper
University Health Care

# SUPPLIER INFORMATION FORM

Legal Name of Company _____

Business Name_____

Mailing Address_____

City_____ State_____ Zip Code_____

Remit Address _____

City _____ State _____ Zip code _____

Telephone Number _____ Fax Number _____

Email _____ Web _____

NAICS/SIC Codes _____

Description of Products/Services provided by your company

| |
|---|
| |

Service area covered or area in which your products are distributed

| |
|---|
| |

EDI Number _____ Duns# _____

Min Order (Y/N) _____ Amount _____

Tax ID# _____ (Include w-9)

Payment Terms _____ Discount Terms _____

Payment formats (Y/N): Credit Card ____ ACH _____ Wire _____

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## Environmentally Preferred Purchasing (EPP) Initiatives

Provide a short description of any of your company's EPP initiatives

## Additional Information

Please provide any additional information about your company that you think would make you a supplier of choice for The Cooper Health System.