Children's Hospital FINANCE department

Children's Hospital Boston

New Vendor Profile Form

Completed Form can be faxed to 617-730-0104
For assistance with completion of this form, please contact your department sponsor at Children's Hospital
Please allow 3 to 5 business days for processing

SECTION A: Requester Information - To be completed by the Children's Hospital Department Sponsor

Requester Name: Fareesa Hasan

Department: Divison of Adolescent and Young Adult Medicine

Extension: 5-1451

Date: 04/26/17

Description of Product/Service Provided by vendor and Scope of Work: **IT management and consulting for web-based research project**

SECTION B: To be completed by all prospective vendors

Part A Vendor Identification

Name: Patrick White

Address: 49 Fairfield Circle

City: Norwood

State: MA **Zip: 02062**

Country: USA

Phone: 6174350346 **Fax:**

Email Address: pat@kalanso.com

Website: kalanso.com

Taxpayer/Employer ID Number: 47-3502314

If remittance address is different, please specify:

Address:

City:

State: **Zip Code:**

Country:

Payment Terms: Children's Payment Terms are Net 30

Note: Please attach a completed Form W9 when submitting this form.
If a non-US company/organization, submit Form W8EXP

Type of Business:

- ☐ Individual*
- ☐ Corporation
- ☒ Sole Proprietor*
- ☐ LLC
- ☐ Partnership

Please Provide Certification

- ☐ Minority Business
- ☐ Other (Specify)
- ☐ Small Business
- ☐ Tax Exempt Entity

* Complete Section C

Does any person employed by, on the board of, or who holds a significant ownership interest in the company (or the immediate family member of any such person) receive any compensation from Children's Hospital Boston (Children's Hospital) or hold a position as a trustee of the hospital?

☐ YES ☒ NO Details if "YES":

Has the company or individual ever been suspended, sanctioned, or restricted from participating in any federal or state health care program (e.g. Medicare or Medicaid), debarred from participating in any government contracts, (or restricted from participating in any private health care network or program (e.g. Blue Cross and Blue Shield provider network listings)?)

☐ YES ☒ NO Details if "YES":

SECTION C: To be completed if the prospective vendor is an individual or sole proprietor (all other vendors continue to Section D)

The information provided below will assist Children's Hospital to determine whether an individual performing services will be classified for tax purposes as an independent contractor. All of the following questions must be completed.

Current Children's Hospital Employee? ☐ YES ☒ NO If yes, not eligible for consulting /service payment

Immediate family member of Children's Hospital Employee? ☒ YES ☐ NO If yes, provide relationship and department below

Yes Dept of Medicine Father

Retired from Children's Hospital and drawing benefits? ☐ YES ☑ NO If yes, must have Human Resources approval

Do you anticipate that you will receive more than 50% of your income this year from Children's Hospital? ☐ YES ☑ NO

Do you make your services available to the general public? ☑ YES ☐ NO

Are your services promoted in trade publications or business directories? ☐ YES ☑ NO

If yes, please provide name(s) of publication(s)

Are your services promoted via the web? ☐ YES ☑ NO

What expenses will you incur in the performance of your duties for Children's Hospital? ☐ Travel Expenses ☐ Training ☑ Supplies, materials, equipment

Will Children's Hospital set the number of hours and/or days of week that you will be required to work? ☑ YES ☐ NO

Will the work be performed on Children's Hospital premises? ☐ YES ☑ NO

Will Children's Hospital determine the methods by which assignments are performed? ☐ YES ☑ NO

Have you previously worked at Children's Hospital as an employee performing a similar service? ☐ YES ☑ NO

If yes, provide title and dates of service

Is it expected that Children's Hospital will hire you as an employee immediately following the end of this agreement? ☐ YES ☑ NO

Do you have proof of professional liability insurance? ☐ YES ☑ NO

If yes, Carrier and/or Certificate #

SECTION D: To be completed by all prospective vendors

1. I a ☑ a US Citizen ☐ a permanent resident ☐ a Foreign National on a visa that authorizes me to perform services in the U.S. (attach copy of visa)

2. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me).

To the best of my knowledge and belief the information in the form above is accurate.

Signature: PP **Date:** 4/27/17

Printed Name: Patrick White

Financial Operations - Procurement Services Use Only

Vendor #

After reviewing the above responses, this service provider is an: PeopleSoft vendor type:

Independent Contractor:_____ Employee: _____ Information will be forwarded to CHB Human Resources

Vendor Verification:

☐ www.OIG.hhs.gov ☐ www.epls.gov ☐ www.treasury.gov/resource-center/sanctions/SDN-List/Pages/default.aspx

Reviewer: Date:

Notes:

