**\*\* Return to GT Medical via email \*\***

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| **Consultant Supplier Information** | | | | | | | |
| Consultant Name: | | | | | | Main Address: | |
| Phone Number: | | Email: | | | |
| Parent Company: | | Web page: | | | |
| **Key Contacts** | **Name** | | **Role** | | **Phone** | | **E-mail** |
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| *<Add others if needed>* | |  | |  | |  |
| *Please answer the following questions.  Explanations or details may be included in the provided space.* | | | | | | | |
| **Question** | | | | **Response** | | | |
| 1. What do you consider your company’s area(s) of expertise? | | | |  | | | |
| 1. What size (number of people) is your company? If greater than 6, please provide organizational chart. | | | |  | | | |
| 1. How long has your company been in business? | | | |  | | | |
| 1. Are you a member of any accredited organizations? | | | |  | | | |
| 1. What certifications do you hold? | | | |  | | | |
| 1. How many people from your company will be supporting this project? Please attach credentials for the key members of your team listed above. | | | |  | | | |
| **Consultant Supplier Survey completed by:** | | | | | | | |
| Name and Title: | | | | Signature & Date: | | | |

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| **CONSULTANT SUPPLIER APPROVAL**  *GT Medical use only.* ***Consultant******Supplier:*** *Do not complete this section.* | | |
| Consultant Supplier Status: | Approved | |
| Not Approved | If Not Approved, state reason: |
| Approved By:(*Print Name and Title*) | | Signature & Date: |

***This form may be input electronically for legibility purposes. Electronic input may result in multiple pages.***