



Wisconsin Badger APIC Chapter 75

VENDOR REPRESENTATIVE REGISTRATION FORM

Application Date ____/____/____

REPRESENTATIVE INFORMATION

Name _____

Title _____

Preferred Mailing Address _____

City, State, Zip _____

Work Phone # _____ Mobile Phone # _____

Fax # _____ Pager # _____

E-mail _____

COMPANY

Name of Company _____

Address _____
(If different than above)

City, State, Zip _____

Company Main Phone # _____

Company Web Address _____

Please Complete both sides of form and return to:

Diane Dohm – Badger APIC Vendor Representative
Infection Prevention and Control Program
Meriter Hospital
202 S Park St
Madison, WI 53715
Phone 608-417-6516
Fax 608-417-5645
ddohm@meriter.com

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 Badger APIC and the vendor representatives regarding confidentiality of patient information.

I understand that I have been permitted to conduct business with Badger APIC. I understand that I am not allowed to discuss or request specific patient information.

I understand that during the course of conducting business, I may come in contact with identifiable information of patients. Identifiable information means any information that identifies a patient, including demographic, financial, and medical, that is created by a health care provider or health plan that relates to the past present or future condition, treatment, or payment of the individual.

I understand that individually identifiable information includes all patient identifiable information in any medium, including, but not limited to oral, written, hard copy, and electronic (whether retrieved on screen or contained on a computer disc).

I understand that individually identifiable information is to be held in strict confidence and I agree that I will not:

1. Review any individually identifiable information not directly relevant to business purposes.
2. Discuss any individually identifiable information with anyone who does not have a legitimate, professional need-to-know the information.
3. Disclose the information to any person or organization outside UWHC without proper, written authorization from the patient except as required by law/ FDA regulations.

I understand that the obligations outlined above will continue after I have conducted my business.

I understand that violation of any of the above may lead to civil and/or criminal penalties pursuant to the Health Insurance Portability and Accountability Act of 1996.

Signature of Vendor Representative

Date

Signature of Badger APIC representative

Date