

BUREAU OF HEALTH SERVICES VENDOR ACKNOWLEDGMENT

By signing below, I hereby acknowledge and understand that:

- I am a Vendor and not a State employee, nor have I been a State employee within the past six months.
- I will not receive any type of benefits as a Vendor, i.e, no health insurance coverage, no holidays, no malpractice insurance, no worker's compensation coverage, no withholding of taxes, no travel reimbursement.
- I am strictly a Vendor providing health care services at an hourly rate.
- I am prohibited from releasing to any unauthorized person any medical information which may come to my attention in the course of my duties. Any breach of confidentiality, patient or otherwise, resulting from my written or verbal release of information or records shall result in the immediate termination of the Authorization to Vendor.
- I have received a copy of the Tennessee Department of Health's policy regarding the maintenance of a drug-free work place. I realize that the unlawful manufacture, distribution, dispensation, possession or use of a controlled substance is prohibited in the workplace or on state property and violation of this policy shall result in the immediate termination of the Authorization to Vendor. I must abide by the terms of this policy and will notify the Department of Health of any criminal drug conviction or a violation occurring in the workplace no later than five (5) days after such conviction. I acknowledge that I have agreed to comply with the Drug-Free Workplace Policy of the Tennessee Department of Health.
- I have received a copy of the Sexual Harassment Policy of the Tennessee Department of Health and agree to comply with the policy.
- I have received a copy of the Conflict of Interest Policy of the Tennessee Department of Health and agree to comply with the policy.

Signature of Vendor

Signature of Witness

Date

Date

Print Vendor's Name

Vendor's Social Security Number