

Instructions: Please provide a response in as many fields as possible; fields left blank will be considered “not applicable” (N/A). Information you provide should reflect the current state of your company, and applies to the facilities that would be used to supply us. The results of this questionnaire will be kept confidential.

| 1.0 Company Contact Information | |
|---------------------------------|-----------------|
| Business Name: | Website: |
| Address Line 1: | |
| Address Line 2: | |
| City: | State / Region: |
| Postal Code: | Country: |
| Telephone: | Fax: |

| 2.0 Company Profile | |
|--|---|
| Year Company Founded: | Type of Business: |
| Incorporation: <input type="checkbox"/> Indiv./Sole proprietor <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Other: | |
| (US only) Federal Tax ID: | (US only) Current W-9 attached <input type="checkbox"/> |
| Dun & Bradstreet # (if any): | 301c-990 ID (US only): |
| Percentage (%) of previous fiscal year's sales to medical device, pharmaceutical, biotechnology, and/or dietary supplement makers: | |
| Are you covered by liability insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No Amount (USD): | |
| To which industry organizations (Better Business Bureau, etc.) do you belong? | |
| Certified Small / Minority / Veteran-Owned Business Confirmation | |
| Are you registered as a SMALL BUSINESS by the US Small Business Administration? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Are you certified as a SMALL DISADVANTAGED / MINORITY-OWNED BUSINESS? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Are you certified as a VETERAN-OWNED BUSINESS? <input type="checkbox"/> Yes <input type="checkbox"/> No | |

| 3.0 Compliance & Quality | |
|---|--|
| Does your company have any/all of the following policies? | |
| <input type="checkbox"/> Quality <input type="checkbox"/> Privacy <input type="checkbox"/> Health & Safety <input type="checkbox"/> Code of Conduct <input type="checkbox"/> Records Management | |
| Is your company certified to any of the following? (If so, please attach certificate copy) | |
| <input type="checkbox"/> ISO () <input type="checkbox"/> A2LA <input type="checkbox"/> NVLAP <input type="checkbox"/> SA8000 <input type="checkbox"/> Other standard: | |
| Have you been cited (enforcement action) by any of the following US agencies or your nation's equivalent in the previous three years? <input type="checkbox"/> CBP <input type="checkbox"/> EPA <input type="checkbox"/> FDA <input type="checkbox"/> OSHA <input type="checkbox"/> Other: | |
| Are you registered with the US Food and Drug Administration (FDA)? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Do you work with any debarred FDA suppliers or personnel (see current listing online at http://www.fda.gov/ICECI/EnforcementActions/FDADebarmentList/)? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Do you work with any debarred US suppliers or personnel (see current listing online at http://www.pmdtc.state.gov/compliance/debar.html)? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Name & contact information for Quality Director: | |

Completed by: _____
(name and title)

Date: _____