**CORPORATE COMPLIANCE VENDOR ACKNOWLEDGEMENT**

**Vendor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Tax ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

### **Initial \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Monthly Check In \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_ Read and understand the Corporate Compliance Procedures (13) available on the Auburn Community Hospital website**

**\_\_\_\_\_\_\_\_ Read and understand the Code of Conduct statement available on the Auburn Community Hospital website**

**\_\_\_\_\_\_\_\_ Read and understand How to Report any Corporate Compliance Issues as stated on the Auburn Community Hospital website**

**\_\_\_\_\_\_\_\_ Completed the monthly exclusion check on vendors employees per the Office of the Medicaid Inspector (OMIG)**

**Note: Exclusion check updates are required monthly and failure to complete in a timely basis may affect continued services with Auburn Community Hospital and its affiliates.**

 **\_\_\_\_\_\_\_\_ No Issues**

 **\_\_\_\_\_\_\_\_ Investigating**

 **Comments \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Completed by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Name (Print) Date**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Signature**

 *Note: The Hospital will take every measure to ensure the confidentiality of the above information. However, there may be circumstances where disclosure of this information may become necessary.*