


**VENDOR REGISTRATION FORM**
**REF:**

For any order with value over \$1,000, vendors/bidders must register with International Medical Corps. If not already a registered vendor, please provide information/documentation as listed on the attached sheet, and confirmation of adherence to International Medical Corps standard Terms and Conditions. This document should be filled by International Medical Corps staff member

COUNTRY	Iraq				
FIELD SITE					
DATE OF REGISTRATION					
NAME OF BUSINESS					
CATEGORY OF SERVICES / SUPPLIES					
Name of owner / manager / official rep					
Vendor address					
Vendor City/Location incl. Zip code	#00964				
Vendor Country	Iraq				
Phone Number including dial code					
Email (for sending RFQ/ITT)					
Web					
Operating hours					
Agreed mean of payment (E-pay)					
Agreed payment terms (30-day from receipt)					
Bank account details					
Legal Registration (number / on file)			DOC ON FILE		YES / NO
Type of business registered for					
Owner Name					
Owner /manager / official rep ID (number / on file)			DOC ON FILE		YES / NO
Tax certification (number / on file)			DOC ON FILE		YES / NO
W9 form (for USA vendors)			DOC ON FILE		YES / NO
Initial Bridger Insight check on file?			DOC ON FILE		YES / NO
Signed Supplier Code of Conduct			DOC ON FILE		YES / NO
Signed Terms & Conditions			DOC ON FILE		YES / NO
Vendor pre-qualified for (type of commodity)			DOC ON FILE		YES / NO
Date pre-qualification					
Physical inspection done / date			DOC ON FILE		YES / NO
Vendor verification done / date			DOC ON FILE		YES / NO
Vendor turnover / year (mention year)					
Number of staff directly employed					
Ownership of equipment					
US Procurement only: Small, Minority Women's Enterprises, Labor Surplus Area Firms					
Other					
<b>REFERENCE CONTROL</b>	<b>CLIENT</b>	<b>TYPE OF CONTRACT</b>	<b>CONTACT</b>	<b>CONTROL DONE?</b>	<b>REFERENCE REPORT ON FILE</b>
Reference 1					YES / NO
Reference 2					YES / NO
Reference 3					YES / NO
Reference 4					YES / NO
<b>COMMENTS</b>					
<b>REGISTRATION DONE BY (User)</b>	<b>INTERNATIONAL MEDICAL CORPS</b>				
Name / Position / Date / Signature / Stamp	Neam Walaa Log. Assistant				
<b>VALIDATION BY (Logistics Desk Officer)</b>	<b>INTERNATIONAL MEDICAL CORPS</b>				
Name / Position / Date / Signature / Stamp					



## VENDOR REGISTRATION FORM (for vendors)

**INSTRUCTIONS:** If not already registered with International Medical Corps, please fill and submit this form and send it to International Medical Corps procurement office or along with your offer as instructed. Please, fill mandatory and recommended fields as appropriate. Fields marked with \* are mandatory at registration stage, \*\* Vendors awarded contracts with value starting \$1,000 and above must provide fields marked

<b>NAME OF BUSINESS*</b>					
<b>Category of supplies*</b>	<input type="checkbox"/> Pharmaceuticals	<input type="checkbox"/> Medical supplies	<input type="checkbox"/> Medical equipment	<input type="checkbox"/> Live stock	<input type="checkbox"/> Vehicles
	<input type="checkbox"/> NFI	<input type="checkbox"/> Food	<input type="checkbox"/> WASH	<input type="checkbox"/> PPE	<input type="checkbox"/> Travel / Accommodation
	<input type="checkbox"/> Transport	<input type="checkbox"/> Communication	<input type="checkbox"/> IT (hardware and software)	<input type="checkbox"/> Security	<input type="checkbox"/> Construction
	<input type="checkbox"/> Office supplies	<input type="checkbox"/> Vehicle rental	<input type="checkbox"/> Property rental	<input type="checkbox"/> Service	<input type="checkbox"/> Other: _____
<b>Official Representative Name*</b>					
<b>Official Representative Position</b>					
<b>Vendor address*</b>					
<b>Vendor City/Location incl. Zip code*</b>	#00964				
<b>Vendor Country*</b>	Iraq				
<b>Phone Number including dial code*</b>					
<b>Email (for sending RFQ/ITT)</b>					
<b>Web</b>					
<b>Operating hours</b>					
<b>Business turnover / year (mention year)</b>					
<b>Number of staff directly employed</b>					
<b>Ownership of equipment</b>					
<b>Other</b>					
<b>Legal Registration (type of business, date, Ref number)**</b>					
<b>Tax certification number**</b>					
<b>Agreed payment terms (IMC standard: 30/45 days invoice)**</b>					
<b>Bank account details (for payment)**</b>					
<b>W9 form (US vendors only)**</b>					
<b>REFERENCES</b>	<b>CLIENT</b>	<b>TYPE OF CONTRACT</b>	<b>NAME OF CONTACT</b>	<b>PHONE/E-MAIL</b>	
Reference 1					
Reference 2					
Reference 3					
Reference 4					
<b>COMMENTS</b>					
<b>REGISTRATION DONE BY</b>			<b>RECEIVED &amp; REVIEWED BY INTERNATIONAL MEDICAL CORPS</b>		
Name / Position / Date / Signature / Stamp					

PLEASE PROVIDE COPY OF:  
 Tax registration certificate (and W9 form for US companies)  
 Company registration document  
 Note: ITT/RFQ may request for additional documents and certificates