**Supplier:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Products:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_**

|  |  |  |
| --- | --- | --- |
| **Supplier Requirements** | **Meets Requirements Yes or No** | **Comments** |
| Are products/equipment supplied FDA licensed? Do they meet or exceed FDA requirements? |  |  |
| Does supplier provide products, equipment, or services that meet our needs? |  |  |
| Is supplier endorsed by facility approved contract? If no, explain why sole source. |  |  |
| Does supplier provide training or support on use of product or equipment? |  |  |
| Are MSDS sheets provided and available? |  |  |
| Is Technical support available when needed? |  |  |
| If current supplier, does delivery of products meet our needs? |  |  |
| If current supplier, have materials performed as expected? |  |  |
| If current supplier, have excessive complaints or reports been made concerning the supplier? |  |  |

**Assessment by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Approved? Yes\_\_\_No\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Approved by Manager:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Approved by**

**Medical Director:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**