

**CONTRACT REQUEST FORM FOR  
COLLEGE OF MEDICINE (COM) UNITS  
REFERRED TO AS  
UNIVERSITY OF FLORIDA PHYSICIANS (“UFP UNIT”)  
(i.e. COM Clinics, B/AR or IS)**

**IMPORTANT - If this is a request for drafting or reviewing an agreement requiring payment through the University Purchasing Office, please direct your request to: University Purchasing, 102 Elmore Hall, PO Box 115250, Gainesville FL 32611, Phone: 352-392-1331, Fax Number 352-392-8837.**

**IMPORTANT NOTICE TO COLLEGE OF MEDICINE -- Please note that pursuant to a directive from the Dean's Office, the Contracts & Related Services Office will submit for review and approval all incoming contract requests containing a clinical component to the Senior Associate Dean and Chief Executive Officer of the Faculty Group Practice, Jane T. Schumaker.**

**The VPHA Contracts Office appreciates your assistance in providing the following detailed information for purposes of drafting the proposed contractual document. If you have questions, please call 273-7007.**

Is there a COM clinic or other UFP Unit that already has an existing contract for this product or service? (The contract may have been entered into by Shands pursuant to the Clinic Support Agreement, by the applicable department of COM, University Purchasing, or UFP.) Yes? \_\_\_\_\_ No? \_\_\_\_\_

If yes, please identify the COM clinic or UFP unit and the legal name of the outside party providing the product or service:

COM Clinic/ UFP Unit \_\_\_\_\_

Legal Name of Outside Party \_\_\_\_\_

**I. TYPE OF DOCUMENT REQUESTED:**

A. Please check all that apply:

New Contract: \_\_\_\_\_ or Amendment to Existing Contract\*: \_\_\_\_\_

Termination \_\_\_\_\_ Renewal \_\_\_\_\_

B. \*Please include if applicable a copy and Contract Office’s Database number of existing contract: \_\_\_\_\_.  
If new request is similar to an existing contract, attach sample document.

**II. REQUESTING COM CLINIC OR OTHER UFP UNIT:**

Name of COM Department, division and/or clinic:

Name, title, and complete address of person who  
should receive all official notices:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**III. OTHER PARTY WISHING TO CONTRACT WITH UFP UNIT:**

A. Provide complete legal name and address of contracting entity(ies): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

B. Is company registered to do business in the state of Florida? \_\_\_\_ Yes \_\_\_\_ No. If no, what state? \_\_\_\_\_

Name, title, and mailing address of person who should receive all official notices:

Name and title of legal signatory to the contract:

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**IV. SCOPE AND PURPOSE OF PROPOSED CONTRACT:**

A. Describe with specificity how the proposed contract furthers the Education, Research, and/or Service mission of the University. **[This is a required field.]** : \_\_\_\_\_

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B. Describe context, background, and scope of services and/or obligations. Please elaborate in writing on additional page(s) and attach to this document: \_\_\_\_\_

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C. Identify complete address of where payments should be sent:

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D. Is there any possibility, however remote; the outside party will have access to patient health information for non-treatment purposes? Yes? \_\_\_\_ No? \_\_\_\_

If Yes, name and contact information for outside party's HIPAA Compliance Officer:

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**V. COMPLETE THIS SECTION IF SERVICES ARE TO BE PROVIDED TO COM CLINIC/ UFP UNIT**

A. Provide detailed description of services and/or obligations of the other party (ies). Please elaborate in writing on additional page(s) and attach to this document. **Provide a copy of all attachments to be incorporated:**

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- B. Legal name of party who will provide services? \_\_\_\_\_
- C. Who will services be provided to (usually, a COM Clinic & Department needs to be identified)?  
\_\_\_\_\_
- D. Amount to be paid for services? \_\_\_\_\_
- E. Has analysis been done to determine whether amount to be paid is fair market value? Yes? \_\_\_\_\_ No? \_\_\_\_\_.  
Please attach any relevant documentation. If no please do so within ten days of request.
- F. Provide times/hours/frequency and location of services by the other party (ies): \_\_\_\_\_
- G. Provide name(s), title(s), and FTE(s) of personnel providing services: \_\_\_\_\_
- H. Describe any licensure/qualification requirements or regulations: \_\_\_\_\_
- I. Describe equipment, space, support personnel, access, and/or other tangibles required. Include information regarding requirements to purchase tangibles and funding of maintenance cost of said tangibles: \_\_\_\_\_

**VI. COMPLETE THIS SECTION IF PRODUCT/PROPERTY IS TO BE PURCHASED/SOLD**

- A. Describe in detail products to be purchased \_\_\_\_\_
- B. Is product medical equipment or supplies? Yes? \_\_\_\_\_ No? \_\_\_\_\_.  
If yes, has Medical director for the COM Clinic approved the purchase? \_\_\_\_\_
- C. Who will purchase products (usually, a COM Clinic & Department needs to be identified)?  
\_\_\_\_\_
- D. Identify Legal Name of outside party who will provide the product: \_\_\_\_\_
- E. Amount to be paid for product? \_\_\_\_\_
- F. Per Unit Price? \_\_\_\_\_ Unit Measurement? \_\_\_\_\_ Total Price? \_\_\_\_\_
- G. Total Units to be purchased? \_\_\_\_\_
- H. Is price fair market value? Yes? \_\_\_\_\_ No? \_\_\_\_\_. Please attach any relevant documentation.

**VII. COMPLETE SECTION IF PROPERTY IS TO BE LEASED**

A. Describe property to be leased? If real property, include physical address of property.

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B. Which party is the lessee (usually FCPA)? \_\_\_\_\_

C. Who will be the tenant(s) (Usually, a COM clinic & Department needs to be identified)?

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D. For each tenant, identify how the space will be used: \_\_\_\_\_

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E. What is the Legal name of the lessor? \_\_\_\_\_

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F. Has Lessor's ownership of property to be leased been verified? \_\_\_\_\_

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G. Amount to be paid for lease? \_\_\_\_\_

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H. Will the leased space be used exclusively by the tenant identified or will there be shared use? If shared, please specify percentage time used by tenant. \_\_\_\_\_

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I. Attach documentation verifying rate is Fair Market Value for square footage and percentage of time used.

J. Complete Lease Summary form and attach to this Contract Request Form.

K. Obtain floor plan identifying portion of space to be leased and attach.

**VIII. CONTRACT DATES:**

A. Effective date of contract: \_\_\_\_\_

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D. Duration/term of contract if other than for an indefinite period: \_\_\_\_\_

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C. Days required for termination notice: \_\_\_\_\_ With Cause: \_\_\_\_\_ Without Cause: \_\_\_\_\_ May party cure a breach? \_\_\_\_\_

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D. Other \_\_\_\_\_

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**IX. OTHER IMPORTANT CONSIDERATIONS, IF ANY, PERTAINING TO THE PROPOSED CONTRACT:**

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**CONTRACT REQUEST FORM APPROVED BY:**

\_\_\_\_\_  
Name, telephone number and e-mail address of person providing  
the above information

\_\_\_\_\_  
Date

\_\_\_\_\_  
Approval of Medical Director (if medical equipment or drugs are being  
purchased/leased)

\_\_\_\_\_  
Date

\_\_\_\_\_  
UFP Director

\_\_\_\_\_  
Date

\_\_\_\_\_  
UFP Financial Services Staff budget approval

\_\_\_\_\_  
Date

\_\_\_\_\_  
Approval of Associate Dean and CEO, UF Faculty Group Practice

\_\_\_\_\_  
Date

\_\_\_\_\_  
Dean's Office, Financial Services Approval

\_\_\_\_\_  
Date

\_\_\_\_\_  
Funding Entity (to be completed by Dean's office)

**Submission of a completed contract request form can be accomplished in a number of ways. You may send the form electronically as an attachment to the office e-mail address at [VPHA-contracts@hsc.ufl.edu](mailto:VPHA-contracts@hsc.ufl.edu); you may call us at 273-7007 for pick-up of the completed form by our courier; or you may route the completed form by personal delivery to Room 4206 in the Orthopaedics and Sports Medicine Institute, 3450 Hull road. If necessary, you may also contact our office manager, Mary Fenton, at 273-7007, to schedule a meeting with a member of our professional staff to discuss different options of a proposed contractual arrangement.**

Last updated 9/5/07 AAH