

**INFORMATION FOR NON-RESEARCH RELATED CONTRACTING**  
**[PLEASE PRINT OR TYPE]**

**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.**

**Please note that pursuant to Health Science Center policy, the Contracts & Related Services Office will submit for review and approval all incoming contract requests to the Dean's Fiscal Office. Additionally, requests containing a clinical component will be submitted to the Senior Associate Dean and Chief Executive Office 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.**

**I. TYPE OF DOCUMENT REQUESTED:**

A. New Contract: \_\_\_\_\_ or Amendment to Existing Contract\*: \_\_\_\_\_ Effective Date: \_\_\_\_\_

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 UNIVERSITY DEPARTMENT/COLLEGE/DIVISION:**

Name of College, Department, and/or Division:

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

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

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

**III. OTHER PARTY:**

A. Provide complete legal name 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:

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

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

**IV. PURPOSE OF 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.]** : \_\_\_\_\_

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

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

\_\_\_\_\_

\_\_\_\_\_ Is grant money involved? \_\_\_\_\_

**V. OBLIGATIONS OF UNIVERSITY:**

A. Provide a detailed description of University's services and/or obligations. **Provide a copy of all attachments to be incorporated:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

B. Provide times/hours/frequency and location of proposed University services: \_\_\_\_\_

\_\_\_\_\_

C. Provide name(s), title(s) and FTE(s) of University personnel providing services: \_\_\_\_\_

\_\_\_\_\_

D. Describe any licensure/qualification requirements or regulations: \_\_\_\_\_

\_\_\_\_\_

E. 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. OBLIGATIONS OF OTHER PARTY:**

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:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

B. Provide times/hours/frequency and location of services by the other party(ies): \_\_\_\_\_

C. Provide name(s), title(s), and FTE(s) of personnel providing services: \_\_\_\_\_

D. Describe any licensure/qualification requirements or regulations: \_\_\_\_\_

E. Describe equipment, space, support personnel, access, and/or other tangibles require. Include information regarding requirements to purchase tangibles and funding of maintenance cost of said tangibles: \_\_\_\_\_

**VII. PAYMENT FOR SERVICES:**

A. Provide the total dollar amount to be paid for services. If payment is based on a percentage, please provide the percentage and annual salary and fringe benefit amount: \_\_\_\_\_

B. If the College of Medicine is to receive payment, please complete the section below; if not, please proceed to Section C:

1. Is the payment for patient care services? Yes? \_\_\_\_\_ No? \_\_\_\_\_
2. If "Yes," what percentage and amount is for patient care services? \_\_\_\_\_.
3. Is the 5.45% Dean's Tax on patient care services included in the total amount? Yes? \_\_\_\_\_ No? \_\_\_\_\_
4. If "Yes," what is the dollar amount of the Dean's Tax? \_\_\_\_\_.

C. Payment Methodology: \_\_\_\_\_

Frequency of Payment? \_\_\_\_\_;

Invoice Required? \_\_\_\_\_

Separate Invoice for Dean's Tax? Yes? \_\_\_\_\_ No? \_\_\_\_\_

1/12? \_\_\_\_\_

Payment in Arrears? \_\_\_\_\_ In Advance? \_\_\_\_\_

Automatic Annual Increase? \_\_\_\_\_

D. If payee is not the University, payee's name and complete address:

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

