



Supplier Creation/Maintenance Form

Suppliers include any business or individual from which SA Health purchases goods and/or services. This form can be used by new suppliers and existing suppliers who would like to update/amend their details.

Please complete all required sections of this form, ensure it is signed by an authorised person.

SECTION 1 – REQUEST TYPE			
☐ New supplier			
☐ Update/amend existing supplier details Supplier ID:			
SECTION 2 – GENERAL SUPPLIER DETAILS			
Registered Trading Name			
Entity Name			
Registered Business Address			
ABN		Registered for GST?	☐ Yes ☐ No
<i>Note: Under Australian Tax Office (ATO) legislation, failure to supply either an ABN or a completed Statement By A Supplier Form will result in withholding tax of 47% deducted from payment.</i>			
SECTION 3 – PURCHASE ORDER DETAILS (purchase orders will be issued to the details outlined below)			
Street Address			
Email for Purchase Orders		Fax for Purchase Orders	
Account Contact's Name			
Position Title			
Contact's Telephone		Contact's Fax	
SECTION 4 – FINANCE DETAILS (payments and remittance advice will be sent to the details outlined below)			
Postal Address			
Email For Remittance			
Name of Financial Institution			
Branch Address			
BSB		Account Number	
Account Name			

NOTES

- Illegible/incomplete forms will be returned to the Requester/Form Authoriser outlined in Sections 5 and 6 for correction.
- All suppliers are added in accordance with standard Department for Health and Wellbeing terms and conditions, including 15 days payment term.
- All payment enquiries should be directed to the SA Dental Schemes unit or email HealthSADSSchemesUnit@sa.gov.au
- Your supplier creation/maintenance form will be forwarded to the Department for the Premier and Cabinet Supplier Maintenance team for action. Please allow up to two (2) business days for Supplier Maintenance to action your approved request.
- A confirmation of account creation/amendment will be emailed to the Form Authoriser outlined in Section 5 once your request has been actioned.

SECTION 5 – FORM COMPLETION (details of the person completing form)			
Name			
Position Title			
Email			
Telephone		Fax	
Signature		Date	

SECTION 6 – FORM AUTHORISATION (details of person authorising form)			
Name			
Position Title			
Email			
Telephone		Fax	
I declare that I have read and understood the above Notes and Conditions. I certify that the information provided in this form is true and correct, in particular, that the registered trading name and ABN provided are strictly in accordance with relevant certificates of registration, and that the above finance details are accurate and provided in good faith. I agree to indemnify SA Health against any loss or damage suffered if any of the information provided is incorrect. I also declare that I am authorised to request the creation/amendment of an account with SA Health.			
Signature		Date	

Fully completed and authorised forms must be emailed to SA Dental Service Dental Schemes Unit, GPO Box 864, Adelaide 5001 or emailed to HealthSADSSchemesUnit@sa.gov.au