GOOD SHEPHERD MEDICAL CENTER
EQUIPMENT PRE-PURCHASE CHECKLIST

TO BE COMPLETED BY DEPARTMENT

Equipment Requested: ______________________________ Model #: ______________________________
Department/Unit: ______________________________ Submitted by: ______________________________

1. Has an ECRI Evaluation of this equipment been requested or received? [ Requested / Received & Attached ]

2. Does this new equipment replace existing equipment? [ Y / N ]
   a. Is department trading in old equipment? [ Y / N ]
   b. Is department disposing of old equipment? [ Y / N ] How?
   c. Is department moving equipment to another department? [ Y / N ] Explain ______________________________

3. Were other manufacturers of same type of equipment evaluated by department? [ Y / N ] Who? ______________________________
   Result of Evaluation: __________________________________________________________________________________

4. Were other hospitals using similar equipment contacted about how they rate the equipment? [ Y / N ] Who? __________
   Comments: ___________________________________________________________________________________________

5. Is this a lease/purchase agreement? [ Y / N ] Duration/Period: _______________________________________________

6. Has a letter been provided by the manufacturer that certifies the requested equipment as Year 2000 compliant?[ Y / N ]
   (Required)
   JUSTIFICATION: _______________________________________________________________________________________

Completed by: ______________________________ Reviewed: ______________________________

TO BE COMPLETED BY VENDOR

If the information provided does not adequately meet the specifications below then the manufacturer/vendor or business supplier
may be removed from consideration as a potential client/business partner.

1. How long has this model been on the market? ______________________________

2. Does the equipment have an embedded microprocessor or microchip? [ Y / N ] If equipment is part of a system, list all
   components of the system that use an embedded microprocessor or microchip: ______________________________

3. Is the equipment under consideration susceptible to RF or EM interference by such things as two-way radios, cellular
   phones, etc.? [ Y / N ] If “Yes” explain shielding requirements, If “No” explain how unit is shielded: ______________________________
4. How long will the manufacturer support equipment with parts and labor? 
   a. How would the support for service and parts be provided and where would support be coming from? 
   ________________
   Response Time? ________________

5. Are there service schools available for GSMC Maintenance Staff? [ Y / N ]
   a. Are they “No Charge” schools? [ Y / N ]
   b. How much do they cost? ________________

6. Are specialized test instruments needed to perform preventative and corrective maintenance? ________________

7. What is the phone # for maintenance/technical support? ________________

8. Does this equipment have any Alerts or Recalls outstanding? [ Y / N ]
   If yes, what and how many? ________________

9. What is the Warranty Period and Response Time; where is it serviced and is a loaner available? ________________

10. What is the lead time for equipment delivery following issuance of purchase requisition? ________________

11. Are parts and service manuals, schematics and diagnostic software included with purchase? [ Y / N ]
    (2 sets of parts/service manuals, schematics and diagnostic software required)
    a. Costs? ________________

12. Is item guaranteed by:
    Manufacturer ________________ Period ________________ Vendor ________________ Period ________________

13. Will additional auxiliary equipment be required? [ Y / N ]
    If yes, on hand? ________________
    To be ordered? ________________

14. Will contract maintenance be required? [ Y / N ]
    By manufacturer? ____________________________
    By local service company? ____________________________
    a. Competency of service personnel as per JCAHO requirements provided with proposal? ________________
    Comments: ________________

15. Utility Services
    a. Energy consumption rate: (kW, hrs., cu. ft., water, lbs. of steam)
    b. Rating of motors: (volts) _______ (amps) _______ (phase)
    c. Availability and cost: (To be completed by Engineering and Vendor) (* Vendor must provide)

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TO BE COMPLETED BY ENGINEERING

1. Physical Checks
   a. Size:
      (1.) Can be unloaded and transported to intended location ________________________________
      (2.) Can be installed in designated area ________________________________________________
   b. Weight:
      (1.) Can be unloaded and installed with hospital personnel and equipment ___________________
      (2.) Floor area will support weight of item ______________________________________________

2. Contact vendor. Is Vendor Competency on file? [ Y / N ] (Try to discuss installation with service personnel)

3. Comments/Recommendations: __________________________________________________________
   __________________________________________________________________________________
   __________________________________________________________________________________

Completed by: _______________________________ Reviewed: ______________________________