



### VENDOR DISCLOSURE STATEMENT

Vendor Name:	VISTA MEDICAL CENTER (EAST) / CORPORATE HEALTH	
Address:	1304 N. SHERIDAN ROAD, WAUKEGAN, IL 60085	
Contact Person:	ROBERT KOREN	Contact Phone #: 847-360-0476
Bid/RFP/SOI/Contract/Renewal:	RFP # 20026	

Vendors wishing to contract with Lake County for goods and services in an amount greater than \$30,000 shall submit this form in advance of award. This disclosure statement is not required for utility companies regulated by the Illinois Commerce Commission or local units of government. Vendors shall disclose:

- A familial relationship between a Lake County elected official, department director, deputy director and manager and owners, principals, executives, officers, account managers or other similar managerial positions of the vendor's company. Familial relationship is defined as a spouse (including civil partner), child, stepchild, parent, stepparent, grandparent, in-laws (including parent, grandparent, sibling, or child), relatives and non-relatives living in the same residence, and offspring born to any aforementioned person.
- All political campaign contributions made by the vendor or an owner, principal, executive, officer, account manager, or other similar managerial position of the vendor to any county board member, county board chair, or countywide elected official within the last five years.

If there is nothing to report in a section, please state none in the appropriate space.

#### FAMILIAL RELATIONSHIPS

*List names and departments/agencies of Lake County employees or public officials with whom owners, principals, or officers of the vendor's company have a familial relationship and the nature of the relationship. Attach additional pages as necessary. (Provide all names or state none in the space below. Do not leave blank.)*

Name and Department/Agency of Lake County Employee/Public Official	Familial Relationship
NA	

#### CAMPAIGN CONTRIBUTIONS

*List campaign contributions that have been made within the last five years that exceed \$150 annually. Attach additional pages as necessary. (Provide all names or state none in the space below. Do not leave blank.)*

Recipient	Donor	Description (e.g., cash, type of item, in-kind service, etc.)	Amount/Value	Date Made
NA				

Continuing disclosure is required if information changes. This Vendor Disclosure Statement form is available at [www.lakecountylil.gov](http://www.lakecountylil.gov).

The full text of the County's Ethics and Procurement policies and ordinances are available at [www.lakecountylil.gov](http://www.lakecountylil.gov).

I hereby acknowledge that the information above is accurate and complete, that I am an authorized signer on behalf of the vendor, that I have read and understand these disclosure requirements, and that I agree to update this information if there are any related changes by submitting a new Vendor Disclosure Statement.

Authorized Signature:		Title:	DIRECTOR - CORPORATE HEALTH
Printed Name:	ROBERT KOREN	Date:	MAY 29, 2020

Vendors must insert "x" in the following box indicating exception and provide a brief narrative for exception.