Vendor Information

VENDOR/PAYEE NAME

Vendor Name: _____ Date: _____

MAILING ADDRESS INFORMATION

Street or PO Box: _____

City: _____

Province/State: _____

Mail Code: _____

Country: _____

REMIT TO ADDRESS (if different from mailing address)

Street or PO Box: _____

City: _____

Province/State: _____

Mail Code: _____

Country: _____

CONTACT INFORMATION

Contact Name: _____ Phone: _____

Email: _____ Fax: _____

BUSINESS CLASSIFICATION

Please check one:

☐ Attorney or Legal Firm

☐ Physician or Medical/Health Care Provider

PAYMENT INFORMATION

1. Does the vendor accept purchasing cards: ☐ Yes ☐ No

2. Does the vendor have an ability to receive ACH payments: ☐ Yes ☐ No

SIGNATURE INFORMATION

The information provided in this vendor information form sections (I), (II), (III), (IV) is true and correct.

Authorized Vendor Signature: _____

THIS SECTION COMPLETED BY COMPANY

Approved by: _____

System Assigned Vendor Code: _____

Date Entered: _____