



VENDOR INTAKE FORM

Vendor Information

Vendor Name: _____ Date: _____

TIN/SSN: _____

Address: _____
Street Address *Apartment/Unit #*

_____ *City* *State* *ZIP Code*

Phone: _____ Email _____

Point of Contact: _____

Invoice Remittance Address

Same as above

Address: _____
Street Address *Apartment/Unit #*

_____ *City* *State* *ZIP Code*

Select All Applicable

<input type="checkbox"/> Corporation	<input type="checkbox"/> Service Disabled Veteran Owned
<input type="checkbox"/> Partnership	<input type="checkbox"/> Small Business
<input type="checkbox"/> Medical Corporation	<input type="checkbox"/> Disabled
<input type="checkbox"/> Non-Resident	<input type="checkbox"/> Large Business (500+)
<input type="checkbox"/> Sole Proprietorship/Independent Contractor	<input type="checkbox"/> Nonprofit Organization
<input type="checkbox"/> Government Entity	<input type="checkbox"/> Disadvantaged Business
<input type="checkbox"/> Tax Exempt Organization under IRS (501) Rules	<input type="checkbox"/> Sheltered
<input type="checkbox"/> 1099	<input type="checkbox"/> Woman Owned Business
<input type="checkbox"/> Native Owned Business	<input type="checkbox"/> Foreign Supplier
<input type="checkbox"/> Veteran Owned Business	<input type="checkbox"/> Limited Liability Company
<input type="checkbox"/> HUB Zone Firm	<input type="checkbox"/> Historically Black College/University