



VENDOR APPLICATION FORM

Request Type: New Revise Information

Tax ID # (FEIN/SSN): _____ (Completed W9 must be submitted with Application)

Name of Company/Individual: _____

DBA: (If different from above) _____

Organization Type: Corporation Individual/Sole Proprietor Joint Venture
 LLC Partnership/Ltd Partnership Non Profit

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Contact Person: _____ Phone: _____ Ext: _____

Email Address: _____ Fax: _____ - _____

Payment Address: (If different from above) _____

City: _____ State: _____ Zip Code: _____

Payment Terms: 60 Days 30 Days **SEND ALL INVOICES TO ACCOUNTSPAYABLE@CFHCONLINE.ORG**

Banking Information

Account Number: _____ Routing Number: _____

References

Name: _____ Phone: _____

Address: _____

Name: _____ Phone: _____

Address: _____

Vendor's Signature: _____ Date: _____

***IF APPLICABLE PLEASE SEND A COPY OF YOUR LIABILITY AND WORKERS COMP INSURANCE**

New Vendor (Required W9 from Vendor)

Vendor Update

Vendor Number: _____

References Verified: Yes No

Vendor Advised: _____

W9 Sent Tax Exempt Cert Sent

Signature: _____

Date Completed: _____