Children's Health System
Supplier Payment & Tax Information Form

To whom it may concern:
To insure payments to your account are properly processed and at the same time correctly reported for tax purposes, we request you complete Section A, along with the appropriate lines in Section B. Initial purchase will not be made until this form is properly completed and returned. Return the signed form to us. In addition, you should be aware that failure to give us your correct name/TIN combination may subject you to a penalty by the IRS. Detailed instructions are on the back of this form.

SECTION A: ACCOUNTS PAYABLE INFORMATION CHS VENDOR #:_____
New Supplier_____ Change to Existing Supplier_____ Customer number_____
Buyer: _____

Type or print the Business Name to appear on payments together with the remit to address for those payments.
Complete Company Name:_____
Remit Address/PO BOX:_____
City_____ County_____State_____Zip Code_____-_____
Customer Service Phone Number: (____) ____-_____ Customer Service Fax Number: (____) ____-_____
Accounts Receivable Phone Number: (_____) _____-_____ AR Fax Number:(____) ____-_____

Payment terms:
No discount offered: Net Due _____ Days OR Net Due On _____ Day of the Month

Discount Offered: Discount % _____ If Paid Within _____ Days, Net Due _____ Days
Discount %_____If Paid on ____Day of Month, Net due _____ Days

Parent Company: _____Other Affiliated Companies:_____
(If Applicable) (If Applicable)

SECTION B: TAX INFORMATION Taxpayer Identification Numbers (TIN)

A. Business Type	B. Name (Please type or print)	C. Social Security Number	D. Employer Identification Number
1. Individual	_____	_____-____-_____	N/A
2. a. Sole Proprietorship	_____	N/A	_____-_____
b. Individual	_____	_____-____-_____	N/A
3. a. Partnership	_____	N/A	____-_____
b. First Partner Listed on TIN Application	_____	N/A	____-_____
4. Corporation Providing Med. Or Health Care Services	_____	N/A	_____-_____
5. Corporation Providing Legal Services	_____	N/A	_____-_____
6. Other	_____	N/A	_____-_____

CERTIFICATION – Under penalties of perjury, I certify that the information provided on this form is correct.
Signature: _____ Date signed:_____

Print Name: _____ Title: _____

Children's Health Systems
Supplier Tax Information Form

Instructions

Tax Information

Insert in the appropriate line of the information needed to report payment to you for tax purposes. The "name" to be entered in column B should be equal to the name listed on your application to the Internal Revenue Service for the TIN you entered in column **C** or **D**.

1. Businesses operation in the name of an individual should complete line 1., columns B and C. If you are a Sole Proprietorship operation in the name of an individual complete line 1 not 2.

2. Sole Proprietorships that applied for their TIN using the business name should complete 2a., columns B and **D** and line **2b**, columns **B** and **C**. If the Sole Proprietor has not taken out an Employer Identification Number for its business name, insert NA in column D, line 2a.

3. Partnerships that applied for their TIN using the business name should complete line **3a**. columns **B** and **D**.

Partnerships that applied for their TIN using the names of the partners hold complete line **3b**. columns **B** and **D**.

4. Corporations providing medical or health care services should complete line **4**, columns **B** and **D**.

5. Corporations providing legal services should complete line **5**, columns **B** and **D**.

6. Complete line **6** columns **B** and **D** for the payees listed below:

a. Corporations providing services other than medical, health care or legal services.
b. Organizations exempt from tax under sections 501© and 501(d) of the Internal Revenue Code.
c. The government or any of its agencies of the United States; a state or foreign country.

7. After completing the appropriate lines please sign the certificate and return the original in the enclosed self –addressed stamped envelope.

Thank you for your prompt attention to this matter!