**Provider: Ordered by:**

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Sponsor’s Name: |  |
| Address: |  | School: |  |
|  |  | Extracurricular Fund: |  |
| Phone Number: |  | Date: |  |

W-9 on file – All independent contractors must complete a W-9.

Select One:

**\*** Paid Service – no contact with students

**\*** FWCS Employee (unrelated to normal job duties of school employees; call Director of Fiscal Affairs with questions)

**\*** FWCS Student

One time, supervised service (e.g., Presenter, Performer) – **Safe Visitor** background check required

Other (e.g., DJ, Photographer, Piano Accompanist, Choreographer, Instructor) – A criminal background check is required. The Unit Secretary must check the **Safe Vendor** program to determine if a criminal history background check has been approved and currently in effect. Safe Vendor background checks expire after one year. If not listed or is expired, follow the procedures provided by the Security, Human Resources and Community Program departments.

* **No background check required**

**Do not complete this agreement until the criminal background check has been successfully completed.**  
 Initials of Unit Secretary (I have verified the background check)

**Agreement for Payments to Independent Contractors for Services Rendered**

|  |  |  |  |
| --- | --- | --- | --- |
| Dates of Service | Duration of Service  (Hours/Days) | Description of Service  (Include hourly or daily rates if applicable) | Payment  Amount |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Persons performing services pursuant to this agreement understand that they are considered independent contractors and that they are not covered by insurance of any nature or entitled to benefits of any nature other than the payment described above. Persons performing services will submit all claim forms and other documents as deemed necessary by Fort Wayne Community Schools for payment of the claim.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Signature Date Unit Head Date