

This form is being created for the workers compensation audit. Going forward the District will need the following information for every vendor.

NEW VENDOR DETAIL (District #99 departments to fill out)

Company Name:

Address:

Phone:

Fax:

Email address:

Description of Business/Services: (detailed explanation is needed)

Does this company work on our premises? _____ Yes _____ No

A Certificate of Liability Insurance is needed for individuals/companies doing business on our property. ***THE WORKERS COMPENSATION SECTION ON THIS FORM MUST BE FILLED OUT BY THE COMPANY.***

Please verify by checking off the boxes below that the certificate is:

On file with department

AND

Attached with this form

Signature

Accounts payable information

Vendor #

Date

W9 Y/N