So the world can see.

Registration

Surgical Facility Registration

Company Information:

Legal Business Name______________________________ Date ____________

DBA Name______________________________

Employer ID or Tax Number______________________ Years in business________

Company Type: ☐ Partnership ☐ Sole Owner ☐ Non-Profit ☐ Corporation

Administrator:

Name________________________ Email____________________ Phone______________

Ship to:______________________________

City______________________________ State________ Zip________________

Bill to Address:

City______________________________ State________ Zip________________

Purchasing Contact:

Name________________________ Email____________________ Phone______________

A/P Contact:

Name________________________ Email____________________ Phone______________

Purchase order required: ☐ Yes ☐ No

Preferred method of payment: ☐ ACH/Wire transfer ☐ Check

Any special instructions for sending invoices______________________________

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Please return the completed form to your local LWVI representative or email it to Accounting@LWVI.org.