LIONS WORLD VISION INSTITUTE™

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 Address:

Address_____

City_____ State_____ Zip_____

Bill to Address:

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_____

_____

_____

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