*** For BPHC use only ***

☐ ADD NEW VENDOR

☐ CHANGE CURRENT
Vendor# _____

Vendor Information Request

***All fields must be completed by the Vendor**

Today's Date: _____/ _____/_____

PAYEE NAME: _____

Address: _____

City: _____ **State**: _____ **Zip Code**:_____

Federal Tax ID: _____ **SSN:**_____ **DUNS #:** _____

Phone No. _____ **Fax No**. _____

E-mail: _____

→ ***Attach W-9, Tax Exempt Certificate, and all other forms that apply**

Business Classification: (Check the Appropriate Boxes - **Please attach certification*)

☐ SOWMBA ☐ Women Enterprise ☐ Minority Owned ☐ City S/LBE

☐ Small Business ☐ Other:_____

Vendor Class: (Check the Appropriate Box)

☐ Client ☐ Student ☐ Settlement ☐ Rent

☐ Independent Contractor ☐ Service Contractor ☐ Supplier ☐ Other:_____

Describe the nature of your business with BPHC:

_____

_____

_____

_____

****** RETURN THIS FORM TO SENDER ******

Authorization agreement for Direct Deposit/ ACH

☐ New ☐ Change ☐ Cancel ☐ Decline

To be completed by vendor:

_____ ("vendor") authorizes Boston Public Health Commission to make payments directly into payee's account at the following Financial Institution and on the following effective date:

_____(Financial Institution Name)

_____ / _____ / _____ (Effective Date). In the event of an overpayment, payee agrees to issue a refund to BPHC within 10 days upon receipt of the overpayment. An official payee representative's signature on this form authorizes payments to the vendor through the ACH system. The information provided on this form will be used to transmit payment data by electronic means to the payee's financial institution. It is understood that if there are any changes to payee's account or payee plans to cancel this agreement, then payee is responsible for notifying BPHC at least 15 days in advance so as to afford a reasonable opportunity to take action.

Payee shall be responsible for any loss which may arise by any error, mistake or fraud concerning the information vendor has provided in this agreement. All transactions under this agreement shall be governed by the rules of the New England Automated Clearing House. Boston Public Health Commission may suspend this agreement at any time.

Name: _____

Address_____

City_____ **State**_____ **Zip**_____

Note: ACH Authorization form will not be accepted without one of the below:

☐ **Attach copy of Check or Deposit Slip**

☐ **Payee's Financial Institution Information – Complete this section if Voided Check or Deposit Slip Not available *(to be completed by Bank)***

☐ **Bank Statement showing *Full Name* and Account Number**

****** BANK USE ONLY ******

Bank Name: _____

Account Type: ___ Checking ___ Savings ___ Other _____

Routing Transit Number (9-Digit): _____ **Account#**: _____

Bank Representative Signature: _____

Print Name: _____ **Title:** _____

Date: _____ / _____ / _____

Authorized Payee's Signature: _____

Print Name: _____ **Title:** _____

Date: _____ / _____ / _____