

HEALTH PLANNING COUNCIL OF SOUTHWEST FLORIDA, INC.

SUBSTITUTE W-9 FORM

REQUEST FOR TAXPAYER IDENTIFICATION NUMBER AND CERTIFICATION

1. Please complete general information:

Taxpayer Name _____

Business Name (if applicable) _____

Address _____

City _____ State _____ ZIP Code _____

Phone Number _____ Fax Number _____ Email _____

Address for Payments (if different) _____

City _____ State _____ ZIP Code _____

2. Circle the most appropriate category below: (please circle only one)

- 1) Individual (not an actual business)
- 2) Sole proprietorship (using a social security number for the taxpayer ID)
- 3) Sole proprietorship (using a federal employer identification number for taxpayer ID)
- 4) A valid trust, estate, or pension trust
- 5) Corporation
- 6) Association, club, religious, charitable, educational, or other non-profit organization (for entities that are exempt from federal tax, use category 8 below)
- 7) Partnership
- 8) Government agencies and organizations that are tax-exempt under Internal Revenue Service guidelines (i.e., IRC 501(c)3 entities)

3. Fill in your taxpayer identification number below: (please complete only one)

1) If you circled number 1-2 above, fill in your Social Security Number.

_____ - _____ - _____

2) If you circled number 3-8 above, fill in your Federal Employer Identification Number (EIN).

_____ - _____

- 4.** Are you a minority organization? Yes No
Are you a foreign organization or non-resident alien? Yes No

5. Sign and date the form:

Certification - Under penalties of perjury, I certify that the number shown on this form is my correct taxpayer identification number. If I circled category 8 above, I also certify that my agency or organization is tax-exempt per Internal Revenue Service guidelines and not subject to backup withholding.

Signature _____ Date _____

Printed Name _____ Title (if applicable) _____