



<b>For Office Use Only:</b>	
Company Code #	_____
Schwan's Location:	_____
Requested By:	_____
(Your name)	

**Vendor Partners Form**

Parent Company Name & Address:

Name \_\_\_\_\_  
 Street (\*) \_\_\_\_\_  
 City \_\_\_\_\_  
 State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Contact Person \_\_\_\_\_  
 Contact Email \_\_\_\_\_  
 Phone \_\_\_\_\_ Fax \_\_\_\_\_

**\* Please no PO Boxes**

Remit Payment to:

Name \_\_\_\_\_  
 Street \_\_\_\_\_  
 P.O. Box \_\_\_\_\_  
 City \_\_\_\_\_  
 State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Contact Person \_\_\_\_\_  
 Contact Email \_\_\_\_\_  
 Phone \_\_\_\_\_ Fax \_\_\_\_\_  
 Payment Terms **Net 30 Days (\*) (\*\*)** FED TAX ID# \_\_\_\_\_

**Legal Entity** (Please check below)  
 Corporation \_\_\_\_\_ Partnership \_\_\_\_\_ LLC \_\_\_\_\_ Individual \_\_\_\_\_

**(\*) A/P policy**  
**(\*\*) If applicable please note any contracted terms.**

**Minority, Small and Women Owned Business Classifications: (Mark all that apply and include certificates)**

African American \_\_\_\_\_ Native American \_\_\_\_\_  
 Alaskan American \_\_\_\_\_ Small Business \_\_\_\_\_  
 Asian American \_\_\_\_\_ Subcontinent Asian \_\_\_\_\_  
 Disability \_\_\_\_\_ Veteran \_\_\_\_\_  
 Hispanic American \_\_\_\_\_ Women \_\_\_\_\_

Ordering Location Name & Address:

(if different)

Name \_\_\_\_\_  
 Street (\*) \_\_\_\_\_  
 City \_\_\_\_\_  
 State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Contact Person \_\_\_\_\_  
 Contact Email \_\_\_\_\_  
 Phone \_\_\_\_\_ Fax \_\_\_\_\_

**\*\*A copy of a blank invoice along with a completed W-9 is required with this form.**

**\*\*Please use your legal business name when filling out this form.**

**\*\*\*Complete ALL Sections of the form.**

**Supplier, please fill out and return to:**  
 ATTENTION: BROWZ

Other \_\_\_\_\_