

PLEASE RETURN COMPLETED FORM IN ENCLOSED POSTAGE-PAID ENVELOPE OR FAX TO: Office of Regional Primary Care Education 919/350-0470

Wake AHEC

An affiliate of WakeMed and the University of North Carolina Area Health Education Centers Program

**Regional Health Education Services
Student & Career Services Division**
3261 Atlantic Avenue, Suite 212
Raleigh, North Carolina 27604-1657
Telephone: 919-350-8547
Fax: 919-350-0470

In order to comply with federal income tax laws, the Internal Revenue Code requires that, with respect to payments made by Wake County Hospital System, Inc. for your products or services, you must provide us with the federal taxpayer identification number assigned to you by the Internal Revenue Service, or your social security number. Provide only your federal taxpayer identification number, or social security number, not both. If you are a sole proprietor doing business under a different name than your own, you must list your name first, then the name of the business, i.e., John Doe DBA General Hospital.

Please fill out ALL parts of the form and return it within 30 days or prior to rendering service, if possible. Thank you in advance for your prompt assistance in completing this form.

CAUTION: THE INCOME FOR THE SERVICES RENDERED WILL BE REPORTED TO THE IRS UNDER THE NAME AND CORRESPONDING SSN OR TIN PROVIDED BELOW.

SUBSTITUTE W-9

Enter Information Below (please print or type)

Complete this form for payments to practice site

Enter Name of Business (or individual if sole proprietor)	
DBA or Attention Line for Mailing	
Address (number and street) That Corresponds to Name in Box 1 Above	
City, State, and ZIP Code	
<p>Please complete this section. Enter your TIN or SSN, <u>not both</u>, that corresponds with Name in Box 1 above. For individuals, including most sole proprietorships, this is your social security number. For other entities, it is your federal employer identification number.</p>	
Social Security # _____	OR EmployerTax Identification # _____
Make Check Payable To: _____	

CIRCLE THE APPROPRIATE RESPONSE TO THE QUESTIONS AS THEY RELATE TO THE NAME IN BOX 1 ABOVE.

Is your firm incorporated?	Yes/No	Is your firm a sole proprietorship?	Yes/No
Is your firm a health or medical service corporation?	Yes/No	If yes, has the IRS assigned the sole proprietorship its own taxpayer identification number?	Yes/No
Has the IRS notified you that you are subject to backup withholding?	Yes/No	If yes, is that taxpayer identification number the one used to report income to the IRS?	Yes/No
Are you an exempt government agency, or a tax-exempt organization?	Yes/No	If yes, is the number listed above your firm's employer identification number?	Yes/No

Signature _____ **Date** _____

Title _____ **Phone** _____