



## *State of New Jersey*

Jon S. Corzine  
*Governor*

**OFFICE OF THE ATTORNEY GENERAL  
DEPARTMENT OF LAW AND PUBLIC SAFETY  
STATE ATHLETIC CONTROL BOARD  
P.O. BOX 180  
TRENTON, NJ 08625-0180**

Anne Milgram  
*Attorney General*

Tony Orlando  
*Chairman*

Steven Katz  
Dennis McDonough  
*Member*

**SYLVESTER CUYLER**  
*Acting Commissioner*

**TO: PROFESSIONAL BOXERS/KICKBOXERS/MIXED MARTIAL ARTISTS  
JUDGES/REFEREES**

**FROM: Larry Hazzard, Sr.  
Commissioner**

**SUBJECT: New Jersey Boxing/Kickboxing/Mixed Martial Arts Judge/Referee License  
Application**

**RENEWAL: July 1, 2007 - June 30, 2008**

**Enclosed are the annual requirements for license as a Professional Boxer  
/Kickboxer/Mixed Martial Artist/Judge/Referee in the State of New Jersey.**

You must submit the following to this office:

1. Completed License Application Form;
2. Completed Physical Examination Form
3. Completed Official's Disclosure Form
4. Original EKG report, interpreted by a physician;
5. Original EYE examination by an optometrist; and
6. Check or money order in the amount of \$75.00 payable to the State Athletic Control Board



TELEPHONE: (609) 292-0317 FAX: (609) 292-3756  
NEW JERSEY IS AN EQUAL OPPORTUNITY EMPLOYER PRINTED ON RECYCLED PAPER AND RECYCLABLE

NOTE: Proof of medical testing must be provided through **ORIGINAL DOCUMENTS** indicating date of test, location of test and identification of the doctor. The date, location and name of doctor who reviews the medical test results must also be provided. Medical tests and examinations must be dated within **180** days of application.

To reduce the costs for individual tests, the Board has obtained an agreement from Occupational Health, Bridgeton Health Center to provide medical testing at specific rates. For further information contact: Occupational Health, Bridgeton Health Center, Ground Floor, 333 Irving Avenue, Bridgeton, New Jersey 08302.  
Phone: 856 575-4835 (direct phone #)  
Fax: 856 453-1218  
E-mail: piercej@sjhs.com

**AN INCOMPLETE APPLICATION WILL BE RETURNED TO YOU, DELAYING ISSUE OF YOUR LICENSE AND FUTURE SHOW ASSIGNMENTS.**

**LICENSEES ARE REMINDED:** You are subject to the requirements of State Athletic Control Board Rules, provided by Chapter 46 of New Jersey's Administrative Code.

If there are any questions regarding your application, please contact the office at 609.292.0317.

LH:tg  
Enclosures  
REV: 05.2005



**\*\*PLEASE MAKE CHECK OR MONEY ORDER PAYABLE TO N.J.S.A.C.B. \*\***

**\*\*\*\*NO CASH!!\*\*\*\***

**NEW JERSEY STATE ATHLETIC CONTROL BOARD  
LICENSE APPLICATION**

*P. O. Box 180*

*Trenton, New Jersey 08625-0180*

*Telephone: (609)292-0317 Fax: (609)292-3756*

**Check (✓) or Circle Type/s of License**

<u>CONTESTANT</u>	<u>MANAGER</u>	<u>SECOND</u>	
<input type="checkbox"/> Boxer \$5	<input type="checkbox"/> Boxing \$25	<input type="checkbox"/> Boxing \$25	<input type="checkbox"/> Announcer \$25
<input type="checkbox"/> Kickboxer \$5	<input type="checkbox"/> Kickboxing \$25	<input type="checkbox"/> Kickboxing \$25	<input type="checkbox"/> Timekeeper \$25
<input type="checkbox"/> Mixed Martial Artist \$5	<input type="checkbox"/> Mixed Martial Arts \$25	<input type="checkbox"/> Mixed Martial Arts \$25	<input type="checkbox"/> Other \$ _____

<u>REFEREE</u>	<u>JUDGE</u>	<u>PROMOTER</u>	<u>MATCHMAKER</u>
<input type="checkbox"/> Boxing \$75	<input type="checkbox"/> Boxing \$75	<input type="checkbox"/> Boxing \$300	<input type="checkbox"/> Boxing \$100
<input type="checkbox"/> Kickboxing \$75	<input type="checkbox"/> Kickboxing \$75	<input type="checkbox"/> Kickboxing \$300	<input type="checkbox"/> Kickboxing \$100
<input type="checkbox"/> Mixed Martial Arts \$75	<input type="checkbox"/> Mixed Martial Arts \$75	<input type="checkbox"/> Mixed Martial Arts \$300	<input type="checkbox"/> Mixed Martial Arts \$100

**SECTION I (All Applicants) - Please Print**

NAME:

AKA or ALIAS (Other Names Used):

ADDRESS:

CITY:

STATE:

ZIP:

COUNTRY:

MAILING ADDRESS (complete if different from above)

CITY:

STATE:

ZIP:

COUNTRY:

TELEPHONE (Residence):

TELEPHONE (Business):

FAX#

E-MAIL ADDRESS:

( )

( )

( )

DATE OF BIRTH:

SOCIAL SECURITY#:

HEIGHT:

WEIGHT:

SEX:

CITIZENSHIP:

PLACE OF BIRTH:

MALE  FEMALE

Have you ever been convicted of a crime? If yes, explain:  YES  NO

Are you presently on any suspension list? If yes, explain:  YES  NO

Have you ever been disqualified in any contest or disciplined for your actions during a contest?  YES  NO  
If yes, explain:

Has any license you've held been revoked? If yes, please explain:  YES  NO

List all other Athletic Commissions in which you are licensed:

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**SECTION II (Boxer's, Kickboxer's & Mixed Martial Artist Only) - Please Print**

Have you ever been hospitalized due to an injury suffered in any contest? If yes, explain:  YES  NO

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Do you have any current medical conditions? If yes, please explain:  YES  NO

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Do you have a manager? If yes, provide name, address & telephone number:  YES  NO

Name: \_\_\_\_\_ Address: \_\_\_\_\_ Telephone No: (\_\_\_\_) \_\_\_\_\_

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Have you had amateur experience? If yes, complete the following questions:  YES  NO

Amateur Record: \_\_\_\_\_ Number of Fights: \_\_\_\_\_

Submission Grappling Record: \_\_\_\_\_

Name of Gym or Club where you trained: \_\_\_\_\_

Name and Telephone Number of Trainer or Manager:

Name: \_\_\_\_\_ Telephone Number: (\_\_\_\_) \_\_\_\_\_

**SECTION III ( Manager's & Second's Only) Please Print**

List names of boxers which you currently manage/second:

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Do you know of any medical conditions which your boxers currently have?: If yes, please explain  YES  NO

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I THE UNDERSIGNED HEREBY DECLARE THAT I HAVE READ THIS APPLICATION AND THAT ALL THE ANSWERS TO THE QUESTIONS ARE TRUE AND COMPLETE. I UNDERSTAND THAT ANY MISREPRESENTATION OR FAILURE TO ANSWER SHALL CONSTITUTE GROUNDS FOR LICENSE REVOCATION AND OR OTHER APPLICABLE LEGAL PENALTIES.

I ALSO UNDERSTAND THAT BY SIGNING THIS APPLICATION THAT I AM AUTHORIZING THE STATE ATHLETIC CONTROL BOARD TO CONDUCT A FULL INVESTIGATION INTO MY BACKGROUND AND ACTIVITIES. I UNDERSTAND THAT THE OFFICE OF THE ATTORNEY GENERAL AND THE NEW JERSEY STATE POLICE MAY PARTICIPATE IN THIS BACKGROUND INVESTIGATION.

TO ALL COURTS, PROBATION DEPARTMENTS, SELECTIVE BOARDS, EMPLOYERS, EDUCATIONAL INSTITUTIONS, FINANCIAL INSTITUTIONS AND ALL GOVERNMENT AGENCIES, FEDERAL, STATE AND LOCAL, WITHOUT EXCEPTION, BOTH FOREIGN AND DOMESTIC. I HAVE APPLIED FOR A LICENSE WITH THE STATE ATHLETIC CONTROL BOARD AND FOR THE PURPOSE OF THIS APPLICATION, YOU ARE HEREBY AUTHORIZED TO RELEASE ANY AND ALL INFORMATION PERTAINING TO ME, DOCUMENTARY OR OTHERWISE, AS REQUESTED BY ANY APPROPRIATE EMPLOYEE, AGENT OR REPRESENTATIVE OF THE STATE ATHLETIC CONTROL BOARD, THE OFFICE OF THE ATTORNEY GENERAL OR THE NEW JERSEY STATE POLICE.

I THE UNDERSIGNED STATE THAT A PHOTOSTATIC COPY OF THIS AUTHORIZATION WILL BE CONSIDERED AS EFFECTIVE AND VALID AS THE ORIGINAL.

FURTHER, I AM AWARE AND AGREE THAT MY SIGNATURE CONSTITUTES A WAIVER OF LIABILITY AS TO THE STATE OF NEW JERSEY AND ITS INSTRUMENTALITIES AND AGENTS FOR ANY DAMAGES RESULTING IN DISCLOSURE OR PUBLICATION IN ANY MANNER, OTHER THAN A WILLFULLY UNLAWFUL DISCLOSURE OR PUBLICATION, OF ANY MATERIAL OR INFORMATION ACQUIRED DURING THE LICENSURE CONSIDERATION PROCESS OR DURING ANY INVESTIGATIONS, INQUIRY OR HEARING.

I HEREBY AUTHORIZE THE RELEASE OF ANY CRIMINAL HISTORY RECORD INFORMATION TO THIS AGENCY ONLY FOR THE EXPRESS PURPOSE OF PROCESSING MY APPLICATION FOR A LICENSE. THE AUTHORITY TO REQUEST CRIMINAL INFORMATION IS SET FOR IN N.J.S.A. 5:2A-15.

I UNDERSTAND THAT THE DISCLOSURE OF MY SOCIAL SECURITY NUMBER ON THIS APPLICATION IS VOLUNTARY AND THAT IT WILL ONLY BE USED FOR PURPOSES OF PROCESSING MY APPLICATION.

DATE: \_\_\_\_\_

SIGNATURE: \_\_\_\_\_



**State of New Jersey  
Department of Law & Public Safety  
State Athletic Control Board**

**CHILD SUPPORT QUESTIONS**

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*Please certify, under penalty of perjury, the following:*

- |   | YES                      | NO                       |
|---|--------------------------|--------------------------|
| 1. Do you currently have a child-support obligation?  | <input type="checkbox"/> | <input type="checkbox"/> |
| a. If "YES", are you in arrears in payment of said obligation?  | <input type="checkbox"/> | <input type="checkbox"/> |
| b. If "YES", does the arrearage match or exceed the total amount payable for the past six months?       | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Have you failed to provide any court-ordered health insurance coverage during the past six months?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Have you failed to respond to a subpoena relating to either a paternity or child-support proceeding? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you the subject of a child-support-related arrest warrant?                                       | <input type="checkbox"/> | <input type="checkbox"/> |

In accordance with N.J.S.A. 2A:17-56.44d, an answer of "YES" to any of the questions numbered 1a through 4 will result in a denial of licensure. Furthermore, any false certification of the above may subject you to a penalty, including, but not limited to, immediate revocation or suspension of licensure.

\_\_\_\_\_   
Applicant's name (please print)

\_\_\_\_\_   
Applicant's signature

\_\_\_\_\_   
Date

**\*Social Security Number:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

You **must** disclose your Social Security Number for the reasons stated below. Failure to do so may result in a denial of licensure or license renewal.

Please return this form to:

State of New Jersey  
State Athletic Control Board  
25 Market Street  
P.O. Box 180  
Trenton, NJ 08625-0180

**PHYSICAL EXAMINATION - OFFICIALS**

- Blood Pressure no higher than 90 m/m Hg.
- Temperature below 100°F or 37°C
- Fundi - no retinopathies or cataracts
- No hernias nor visceromegaly
- Normal Romberg and finger to nose test
- No suppurative lesions on skin
- No indications of active renal disease

**EXAMINATION**

Ears  
Otoscopy (Normal-Abnormal) Describe:  
\_\_\_\_\_

Mouth pharynx (teeth) (Normal-Abnormal) Describe:  
\_\_\_\_\_

Adenopathys No Yes (Location)  
\_\_\_\_\_

Lungs (Normal-Abnormal) Describe:  
\_\_\_\_\_

Heart (Normal-Abnormal) Describe:  
\_\_\_\_\_

Abdominal palpation (Normal-Abnormal) Describe:  
\_\_\_\_\_

Hernias (No-Yes) Describe:  
\_\_\_\_\_

Testis (Normal-Abnormal) Describe:  
\_\_\_\_\_

Tendon Reflexes	Normal	Abnormal
Knee jerk	Rt. ___ Lft. ___	Rt. ___ Lft. ___
Babinski	Rt. ___ Lft. ___	Rt. ___ Lft. ___

Rhomberg: \_\_\_\_\_  
Finger to nose: \_\_\_\_\_

Upper Extremities (Normal-Abnormal) Describe:

Hands: \_\_\_\_\_  
Wrist: \_\_\_\_\_  
Elbows: \_\_\_\_\_  
Shoulder Girdle: \_\_\_\_\_  
Lower Extremities: \_\_\_\_\_

Skin (Open or Suppurative lesions) Yes No  
\_\_\_\_\_

Urinalysis:  
Albumin: \_\_\_\_\_  
Glucose: \_\_\_\_\_  
Micro: \_\_\_\_\_  
Hematuria: \_\_\_\_\_

Blood-test:  
Hemoglobin and Hematocrit \_\_\_\_\_

Electrocardiogram \_\_\_\_\_ Date: \_\_\_\_\_

Examiners comments:  
\_\_\_\_\_

Physician  
Name (printed): \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Name: \_\_\_\_\_

Home Address:  
\_\_\_\_\_

Phone: \_\_\_\_\_

Birth Date: \_\_\_\_\_

Exam Date: \_\_\_\_\_

**IMPORTANT**

**BLOOD TYPE:** \_\_\_\_\_

**ALLERGIES:**  
\_\_\_\_\_

Pulse: \_\_\_\_\_ Blood Pressure: \_\_\_\_\_

Temperature: \_\_\_\_\_ Weight: \_\_\_\_\_

**OPTOMETRIST EXAM DATE:** \_\_\_\_\_

EYES	RIGHT	LEFT
Distant Vision	20/	20/
Light Reflex	Normal Abnormal	Normal Abnormal
Accommodation Reflex	Normal Abnormal	Normal Abnormal

Comments:  
\_\_\_\_\_

Physician:  
Name (printed): \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

## OFFICIAL'S DISCLOSURE FORM

1. What is your profession or occupation? \_\_\_\_\_

2. Who is your current employer? \_\_\_\_\_

If not currently employed, please list your most recent employer?

\_\_\_\_\_

3. What is your business address and telephone number?

\_\_\_\_\_

\_\_\_\_\_

4. What is your home address and telephone number?

\_\_\_\_\_

\_\_\_\_\_

-over-

5. Are you licensed as a professional boxing official in any other jurisdiction?

YES

NO

(If yes, please explain) \_\_\_\_\_

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6. Has any boxing license you have ever held been suspended or revoked?

YES

NO

(If yes, please explain) \_\_\_\_\_

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7. Have you ever been denied a professional boxing official's license?

YES

NO

(If yes, please explain) \_\_\_\_\_

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8. Do you have any direct or indirect financial interest in, or direct or indirect financial dealings with, any professional boxer, manager, second, trainer, promoter, matchmaker, sanctioning organization, or boxing media personality?

YES

NO

(If yes, please explain) \_\_\_\_\_

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-more-

9. Do you have any direct or indirect financial interest with any company, partnership, or individual who is involved in the sport of boxing?

YES

NO

(If yes, please explain) \_\_\_\_\_

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10. Please list all organizations, associations, groups, or charitable foundations related to boxing that you are currently a member of, or have been in, the last 12 months.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

11. Are you, your spouse, or any of your parents, brothers, sisters, cousins, nieces, nephews, aunts, uncles, or grandchildren related to any professional boxer, manager, second, trainer, promoter, matchmaker, sanctioning organization official, or boxing media personality?

YES

NO

(If yes, please explain) \_\_\_\_\_

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12. Are you, your spouse, or any of your parents, brothers, sisters, cousins, nieces, nephews, aunts, uncles, or grandchildren a personal friend of any professional boxer, manager, second, trainer, promoter, matchmaker, sanctioning organization official, or boxing media personality?

YES

NO

(If yes, please explain) \_\_\_\_\_

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-over-

13. Have you been offered or received any gifts, complementaries, or other things of value from any professional boxer, manager, second, trainer, promoter, matchmaker, sanctioning organization, or boxing media personality?

YES

NO

(If yes, please explain) \_\_\_\_\_

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14. Have you been arrested by any law enforcement agency in the past twelve months?

YES

NO

(If yes, please explain) \_\_\_\_\_

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I CERTIFY THAT THE INFORMATION WHICH I HAVE PROVIDED ABOVE IS TRUE AND ACCURATE AND I UNDERSTAND THAT IT IS MY OBLIGATION TO NOTIFY THE SACB, IN WRITING, IMMEDIATELY, IF ANY OF MY RESPONSES TO THE ABOVE QUESTIONS CHANGE. I FURTHER UNDERSTAND THAT ANY OMISSIONS, INACCURACIES OR THE FAILURE TO MAKE FULL DISCLOSURES MAY BE DEEMED SUFFICIENT REASON TO DENY A LICENSE OR TO WITHHOLD RENEWAL OF, OR SUSPEND OR REVOKE, A LICENSE IF ISSUED BY THE BOARD. THE UNDERSIGNED APPLICANT UNDERSTANDS THE BOARD OR COMMISSIONER MAY MAKE SUCH INQUIRY AND INVESTIGATION CONCERNING THE APPLICANT'S RECORD OR BACKGROUND AS THE BOARD OR COMMISSIONER, IN THEIR JUDGEMENT, DEEMS PROPER, AND SAID APPLICANT FURTHER AGREES TO FURNISH ANY ADDITIONAL INFORMATION REQUESTED BY THE BOARD OR COMMISSIONER.

Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

Signature: \_\_\_\_\_

This form must be faxed back to the SACB at (609) 292-3756 at least 10 days before the scheduled event in order to be considered for a position at that event. If you have any questions, please contact the SACB at (609) 292-0317.

**STATE OF NEW JERSEY  
W-9/QUESTIONNAIRE**

THE STATE OF NEW JERSEY REQUIRES COMPLETION OF THE W-9/VENDOR QUESTIONNAIRE TO VERIFY/ESTABLISH YOUR NAME, ADDRESS, AND TAXPAYER ID ON STATE RECORDS. PLEASE REVIEW THE INFORMATION BELOW, CORRECT ERRORS, AND ANSWER THE QUESTIONS PER SPECIFIC INSTRUCTIONS. RETURN THE COMPLETED FORM TO THE STATE IN THE ENVELOPE PROVIDED AS SOON AS POSSIBLE.

**IMPORTANT:** YOU WILL NOT BE PAID BY THE STATE OF NEW JERSEY UNTIL THIS FORM IS COMPLETED, SIGNED, AND RETURNED TO THE STATE OF N.J. FOR ADDITIONAL INFORMATION CALL (609) 292-8124.

<b>PART I.</b> <b>NAME/ADDRESS</b> (REMIT TO:)	<b>REQUEST FOR TAXPAYER IDENTIFICATION NUMBER AND CERTIFICATION</b> Enter your taxpayer identification number and indicate whether it is a social security or employer identification number by marking the appropriate box.	Return completed form to: <b>OMB VENDOR CONTROL</b> PO BOX 221 TRENTON, N.J. 08625 FAX 609-292-4882
		Make any corrections to the pre-printed data in the space provided below. Please type or print clearly.

<b>4. Taxpayer Identification Number</b> (Enter your correct TIN below ONLY if it differs from the # printed in the box.) <div style="display: flex; align-items: center; margin-top: 5px;"> <div style="border: 1px solid black; width: 150px; height: 20px; margin-right: 10px;"></div> <div style="display: flex; gap: 5px;"> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div> </div>	<b>MARK THE APPROPRIATE BOX:</b> <input type="checkbox"/> SOCIAL SECURITY NUMBER <input type="checkbox"/> EMPLOYER IDENTIFICATION NUMBER
<b>5. For Payees Exempt From Backup Withholding</b> (Contact the IRS for instructions)	<b>Requester's name and address (optional)</b>
<b>6. Certification: Under penalties of perjury, I certify that:</b> (1) The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me) AND (2) I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding.  <b>Certification Instructions:</b> You must cross out item (2) above if you have been notified by the IRS that you are currently subject to backup withholding because of underreported interest or dividends on your tax return. For real estate transactions, item (2) does not apply. For mortgage interest paid, the acquisition or abandonment of secured property, cancellation of debt, contributions to an IRA, and generally payments other than interest and dividends, you are not required to sign the Certification, but you must provide your correct TIN.	

Please Sign Here	Signature >	Date >
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<b>PART II. VENDOR DATA</b>	<b>STATE OF NEW JERSEY VENDOR INFORMATION QUESTIONNAIRE</b>						
<b>1. Enter the code from the list below that best describes your business function:</b> <table style="width:100%; font-size: small;"> <tr> <td align="center" colspan="2"><u>VENDORS</u></td> <td align="center" colspan="2"><u>GOVERNMENTAL ENTITIES</u></td> </tr> <tr> <td style="width:50%; vertical-align: top;"> <input type="checkbox"/> HC = HEALTH CARE SERVICE (NON-STATE AGENCIES)  <input type="checkbox"/> VG = VENDORS WHO SELL OR MANUFACTURE GOODS  <input type="checkbox"/> VS = VENDORS WHO RENDER A SERVICE OR VENDORS WHO RECEIVE RENT PAYMENTS   <input type="checkbox"/> <u>MISCELLANEOUS VENDORS</u>            OT = OTHER MISCELLANEOUS VENDORS (Please Specify) _____         </td> <td style="width:50%; vertical-align: top;"> <input type="checkbox"/> AC = AUTHORITY/COMMISSION  <input type="checkbox"/> CF = CONFIDENTIAL FUND  <input type="checkbox"/> CM = COUNTY/MUNICIPAL GOVT.  <input type="checkbox"/> CU = STATE COLLEGE/UNIVERSITY  <input type="checkbox"/> EP = NJ STATE EMPLOYEE  <input type="checkbox"/> FA = FEDERAL AGENCY   <input type="checkbox"/> FD = FIRE DISTRICT  <input type="checkbox"/> PC = PETTY CASH  <input type="checkbox"/> SA = STATE AGENCY  <input type="checkbox"/> SD = SCHOOL DISTRICT  <input type="checkbox"/> WB = WELFARE BOARD         </td> </tr> </table>		<u>VENDORS</u>		<u>GOVERNMENTAL ENTITIES</u>		<input type="checkbox"/> HC = HEALTH CARE SERVICE (NON-STATE AGENCIES) <input type="checkbox"/> VG = VENDORS WHO SELL OR MANUFACTURE GOODS <input type="checkbox"/> VS = VENDORS WHO RENDER A SERVICE OR VENDORS WHO RECEIVE RENT PAYMENTS  <input type="checkbox"/> <u>MISCELLANEOUS VENDORS</u> OT = OTHER MISCELLANEOUS VENDORS (Please Specify) _____	<input type="checkbox"/> AC = AUTHORITY/COMMISSION <input type="checkbox"/> CF = CONFIDENTIAL FUND <input type="checkbox"/> CM = COUNTY/MUNICIPAL GOVT. <input type="checkbox"/> CU = STATE COLLEGE/UNIVERSITY <input type="checkbox"/> EP = NJ STATE EMPLOYEE <input type="checkbox"/> FA = FEDERAL AGENCY  <input type="checkbox"/> FD = FIRE DISTRICT <input type="checkbox"/> PC = PETTY CASH <input type="checkbox"/> SA = STATE AGENCY <input type="checkbox"/> SD = SCHOOL DISTRICT <input type="checkbox"/> WB = WELFARE BOARD
<u>VENDORS</u>		<u>GOVERNMENTAL ENTITIES</u>					
<input type="checkbox"/> HC = HEALTH CARE SERVICE (NON-STATE AGENCIES) <input type="checkbox"/> VG = VENDORS WHO SELL OR MANUFACTURE GOODS <input type="checkbox"/> VS = VENDORS WHO RENDER A SERVICE OR VENDORS WHO RECEIVE RENT PAYMENTS  <input type="checkbox"/> <u>MISCELLANEOUS VENDORS</u> OT = OTHER MISCELLANEOUS VENDORS (Please Specify) _____	<input type="checkbox"/> AC = AUTHORITY/COMMISSION <input type="checkbox"/> CF = CONFIDENTIAL FUND <input type="checkbox"/> CM = COUNTY/MUNICIPAL GOVT. <input type="checkbox"/> CU = STATE COLLEGE/UNIVERSITY <input type="checkbox"/> EP = NJ STATE EMPLOYEE <input type="checkbox"/> FA = FEDERAL AGENCY  <input type="checkbox"/> FD = FIRE DISTRICT <input type="checkbox"/> PC = PETTY CASH <input type="checkbox"/> SA = STATE AGENCY <input type="checkbox"/> SD = SCHOOL DISTRICT <input type="checkbox"/> WB = WELFARE BOARD						
<b>2. Enter Primary Contact Information Below.</b> PHONE: (____) _____ - _____ NAME: _____ TITLE: _____							
IF YOU ARE A NJ STATE EMPLOYEE, NJ MANAGER OF A CONFIDENTIAL FUND OR A PETTY CASH FUND, DO NOT ANSWER THE BALANCE OF THE QUESTIONNAIRE.							
<b>3. What is the principal activity of your organization?</b> <input type="checkbox"/> M = MANUFACTURING    H = HEALTH RELATED SERVICE <input type="checkbox"/> S = SERVICE            G = GOVERNMENT    O = OTHER (Please Specify) _____							
<b>4. Enter the code from the list below that best describes your organization:</b> <input type="checkbox"/> C = CORPORATION    I = INDIVIDUAL    P = PARTNERSHIP <input type="checkbox"/> A = ASSOCIATION    J = JOINT            O = OTHER (Please Specify) _____							
<b>5. Enter your 4 digit County/Municipality Code for NJ Addresses ONLY</b> (See reverse side for appropriate code.) <div style="border: 1px solid black; display: inline-block; width: 40px; height: 20px; margin-bottom: 5px;"></div>							

**IMPORTANT: ANSWER ALL QUESTIONS (Please Print or Type Clearly)**