



## VENDOR INFORMATION

Kindly supply the following information:

Vendor\* Name: \_\_\_\_\_  
\_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Country: \_\_\_\_\_

### PRIMARY CONTACT PERSON

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

Position/Title: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax Number: \_\_\_\_\_

Address  
(if different from above) \_\_\_\_\_  
\_\_\_\_\_

LIST ANY OTHER KEY INDIVIDUALS ON A SEPARATE SHEET OF PAPER, IF SUCH INFORMATION IS APPROPRIATE. LIST ATTACHED: **YES** \_\_\_\_\_ **NO** \_\_\_\_\_

### LOCATION OF PROGRAM

City: \_\_\_\_\_ State: \_\_\_\_\_

DATE(S) TO BE HELD: \_\_\_\_\_

ATTACH A COPY OF THE PRINTED PROGRAM  
IF THERE WILL **NOT** BE A PRINTED PROGRAM, CHECK HERE: \_\_\_\_\_

\_\_\_\_\_  
NAME OF PERSON COMPLETING FORM DATE

\_\_\_\_\_  
SIGNATURE

\* As used here, the term VENDOR refers to the person or persons, group or groups, offering the proposed program.

**RETURN FORM TO:** N.C. State Board of Optometry  
109 North Graham Street  
Wallace, NC 28466

