

**NORTH AMERICAN PEDIATRIC RENAL TRIALS COLLABORATIVE STUDIES
PARTICIPATING CENTER PAYMENT INFORMATION FORM – REVISED 02/20/09**

TYPE OF BUSINESS (Check One)

- 1 Corporation (Tax Exempt)
- 2 Corporation (Providing Medical Services)
- 3 Corporation (All Other)
- 4 Government Agency
- 5 Joint Venture
- 6 Partnership
- 7 Individual (Including DBAs – i.e., doing business under a name other than your own)
- 8 Other, please specify _____

TAX IDENTIFICATION NUMBER

Individual (Social Security Number)

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OR

All Other (Federal I.D. Number)

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Center Number:

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- | |
|---|
| <input type="checkbox"/> Transplant
<input type="checkbox"/> Dialysis
<input type="checkbox"/> CRI (Check all that is applicable) |
|---|

**Important: If you enter a Social Security Number, you must list an individual's name.
If you enter a Federal ID Number, you must list a company name.**

Check made payable to: _____

Payee Address:
(PLEASE PRINT) _____

Telephone Number: _____

Person Filling out Form (PLEASE PRINT): _____

PI Approved Signature: _____ **Date:** _____

Under penalties of perjury, I certify that the number shown on this form is the correct Taxpayer Identification Number (TIN).

**PLEASE COMPLETE AND MAIL OR FAX ORIGINAL TO:
NAPRTCS DCC**

**The EMMES Corporation
401 N. Washington St., Suite 700
Rockville, MD 20850
301-251-1355 (FAX)**

For Office Use Only
Vendor ID Number
30220

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