



TEXAS A&M
HEALTH
SCIENCE
CENTER

Customer Information Form

Business or Individual Customer Name:		Federal ID or Social Security Number	TAMHSC Customer Number (if assigned)
_____		_____	_____
Customer Information:			
Address:			
_____		_____	
City:	_____	Accounts Payable Contact Name:	_____
State:	Zip:	Email Address	_____
_____	_____	_____	_____
Phone:	_____	Phone:	_____
_____	_____	_____	_____
Fax:	_____	Fax:	_____
_____	_____	_____	_____

Name:	_____	Title:	_____
Customer Representative	_____	_____	_____
Signature:	_____	Date:	_____

This form must be completed in order to extend credit and allow our customers to pay for goods/services at a later date.
PAST DUE INVOICES ARE SUBJECT TO BEING REPORTED TO THE STATE COMPTROLLER AND/OR A COLLECTION AGENCY

TAMHSC Departmental Certification:

I have verified the identification of the customer requesting this service.

Department Name:	_____	Dept Rep Name:	_____
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Mail or Fax Completed Form to: (Department Address & FAX NO.)	_____	Department Rep Signature:	_____
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