



INSTRUCTIONS TO ORIGINATOR:

- a. Complete Section I and if over \$500 forward to the Director of Human Resources for approval prior to event.
b. Complete Section II upon completion of lecture.
c. Is the Presenter/Lecturer a current SFSU employee?
Yes - Submit completed form to Human Resources.
No - Submit completed form to Accounts Payable. (Include Vendor Data Record form or check cannot be issued)

SECTION I:

- 1. College
2. Department/Project
3. Date, time and location of event
4. Describe event and purpose for Honorarium
5. Presenter/Participant/Recipient Name
6. If for an individual NOT an SFSU employee, provide account #:
If for an SFSU employee, provide appropriate position #: Agency Unit Serial No.
7. Amount: \$
8. I CERTIFY that the services listed are necessary to the sponsored activity and that there are sufficient funds available for this transaction.
Dean/Director Date
9. Director of Human Resources (if over \$500) Associate Vice President, ORSP (if applicable)
Approved: Date Date

SECTION II:

- 10. INVOICE for services rendered:
I certify that I have completed the services as described in Section I, and I request payment in the amount indicated above as payment in full for services rendered. I am am not a current University employee.
Signature of Presenter/Participant/Recipient SSN#
11. Hold check for pick up at the Disbursement Office (Administration 351).
Please mail check to: (must be typed or printed)
Name of Presenter/Participant/Recipient
Address
City State/Zip Phone #
12. I certify that the above services have been satisfactorily completed.
Signature of Dean/Director: Date
Budget verification for ORSP (if applicable): Date

STATE OF CALIFORNIA
VENDOR DATA RECORD

(Required in lieu of IRS W-9 when doing business with the State of California)

STD. 204 (REV. 8-95)(SFSU REV.05/01)

V # _____

NOTE: Governmental entities, federal, state, and local (including school districts) are not required to submit this form.

SECTION 1 must be completed by the requesting state agency before forwarding to the vendor

1	DEPARTMENT/OFFICE San Francisco State University/ Purchasing Department	PURPOSE: Information contained in this form will be used by state agencies to prepare Information Returns (Form 1099) and for withholding on payments to nonresident vendors. Prompt return of this fully completed form will prevent delays when processing payments. (See Privacy Statement on reverse.)
PLEASE RETURN TO:	STREET ADDRESS 1600 Holloway Avenue - ADM 361	
	CITY, STATE, ZIP CODE San Francisco, CA 94132	
	TELEPHONE NUMBER FAX: 415-338-1833 415-338-1984	

2 VENDOR'S BUSINESS NAME SOLE PROPRIETOR-ENTER OWNER'S FULL NAME HERE <i>(Last, First, M.I.)</i> MAILING ADDRESS <i>(Number and Street or P.O. Box Number)</i> <i>(City, State, and Zip Code)</i>	3 TYPE OF BUSINESS <input type="checkbox"/> DISABLED VETERAN BUSINESS ENTERPRISE <input type="checkbox"/> CERTIFIED AS SMALL & MINORITY OWNED <input type="checkbox"/> CERTIFIED AS MINORITY OWNED <input type="checkbox"/> CERTIFIED AS WOMAN OWNED <input type="checkbox"/> CERTIFIED AS WOMAN AND MINORITY OWNED <input type="checkbox"/> GOVERNMENT <input type="checkbox"/> LARGE BUSINESS <input type="checkbox"/> UNKNOWN <input type="checkbox"/> CERTIFIED SMALL BUSINESS
---	--

4 CHECK ONE BOX ONLY VENDOR ENTITY TYPE <input type="checkbox"/> MEDICAL CORPORATION (including dentistry, podiatry, psychotherapy, optometry, chiropractic, etc.) <input type="checkbox"/> EXEMPT CORPORATION (Non-profit) <input type="checkbox"/> ALL OTHER CORPORATIONS <input type="checkbox"/> PARTNERSHIP <input type="checkbox"/> ESTATE OR TRUST <input type="checkbox"/> INDIVIDUAL/SOLE PROPRIETOR	5 ETHNICITY CODE - CHECK ONE BOX ONLY <input type="checkbox"/> BLACK MALE <input type="checkbox"/> PACIFIC ISLANDER MALE <input type="checkbox"/> BLACK FEMALE <input type="checkbox"/> PACIFIC ISLANDER FEMALE <input type="checkbox"/> PACIFIC ASIAN MALE <input type="checkbox"/> NATIVE AMERICAN MALE <input type="checkbox"/> PACIFIC ASIAN FEMALE <input type="checkbox"/> NATIVE AMERICAN FEMALE <input type="checkbox"/> HISPANIC MALE <input type="checkbox"/> FILIPINO MALE <input type="checkbox"/> HISPANIC FEMALE <input type="checkbox"/> FILIPINO FEMALE <input type="checkbox"/> WHITE MALE <input type="checkbox"/> ASIAN INDIAN MALE <input type="checkbox"/> WHITE FEMALE <input type="checkbox"/> ASIAN INDIAN FEMALE <input type="checkbox"/> UNKNOWN
---	--

6	SOCIAL SECURITY NUMBER REQUIRED FOR INDIVIDUAL/SOLE PROPRIETOR BY AUTHORITY OF THE REVENUE AND TAXATION CODE SECTION 18646 (See reverse) FEDERAL EMPLOYER'S IDENTIFICATION NUMBER (FEIN) IF VENDOR ENTITY TYPE IS A CORPORATION, PARTNERSHIP, ESTATE OR TRUST, ENTER FEIN .	NOTE: Payment will not be processed without an accompanying taxpayer I.D. number. SOCIAL SECURITY NUMBER IF VENDOR ENTITY TYPE IS INDIVIDUAL/SOLE PROPRIETOR, ENTER SSN .
----------	---	---

7	CHECK APPROPRIATE BOX(ES) For California Tax Purposes: <input type="checkbox"/> California Resident - Qualified to do business in CA or a permanent place of business in CA <input type="checkbox"/> Nonresident (See Reverse) Payments for services by nonresidents may be subject to state withholding <input type="checkbox"/> WAIVER OF STATE WITHHOLDING FROM FRANCHISE TAX BOARD ATTACHED <input type="checkbox"/> SERVICES PERFORMED OUTSIDE OF CALIFORNIA For Federal Tax Purposes: <input type="checkbox"/> US Citizen or Permanent Resident Alien (Green Card Holder) <input type="checkbox"/> Nonresident Alien (Not a US Citizen or a Permanent Resident Alien (see note C)	NOTE: A. An estate is a resident if decedent was a California resident at time of death. B. A trust is a resident if at least one trustee is a California resident. (See Reverse.) C. If the individual is not a US Citizen or Permanent Resident Alien (Green Card Holder), the individual must complete an additional form to determine US tax residency.
----------	--	---

9	I hereby certify under penalty of perjury that the information provided on this document is true and correct. If my residency status should change, I will promptly inform you.	
CERTIFYING SIGNATURE	AUTHORIZED VENDOR REPRESENTATIVE'S NAME (Type or Print) SIGNATURE	TITLE PH #: FAX:
	DATE	