



2016 Service Provider Application

Complete, sign, and email to: tymesavers1@gmail.com

If you prefer you may fax to: 315-452-3361 (when you fax, please send an email to tymesavers1@gmail.com to notify us of the fax you send so we can process your application immediately).

Please type or print clearly.

Today's Date _____

I.

Title: Mr. Mrs. Miss Dr. _____

First Name _____ MI _____ Last Name: _____

DOB _____ SSN _____ (Don't write in SSN. It will be filled in during in-person meeting or over the phone)

II.

Home/Mailing Address _____
Number Street City State Zip

Home Phone _____ Cell Phone _____

Email _____ Fax _____

Please attach to this application, the following:

- A recent police clearance report (obtained within the last three months)
- A valid state issued drivers license
- W9 (attached)

III.

Business Registration (Attach copy of your business registration forms and a photo ID if you are a registered business) Tax ID # _____

__ Sole Proprietary __ Partnership __ LLC/LLP __ S Corporation __ C Corporation __ Not Registered

Business Address _____
Number Street City State Zip

Business Details (Bring a copy of your business insurance page showing coverage level and type and proof of bonding)

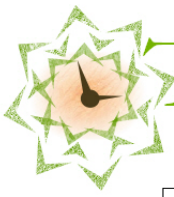
- What is your primary line of business?

- How many employees do you have?

- Do you carry business insurance? _____ If yes, what type and coverage level?
- Are you bonded? _____

IV.

Other Information



TymeSavers

Concierge Services

- Do you work outside Onondaga County? _____ If yes, which additional counties? If no are you willing? _____
- Do you currently drive? ____ Yes (Please provide valid auto insurance and copy of drivers license) ____ No
- Depending on the position you are applying for, you may have to be able to lift weight that is typical with normal grocery shopping items. Are you able to lift such weight? ____ Yes ____ No

V.

Service Provider Annual Affiliation Fee and Method of Payment (For Businesses Applicants Only)

Per service agreement:

- Your annual affiliation fee specific to your service provider level is \$ _____
- Your service calls amount will be ____% of each service performed for our clients.

Payment of the annual affiliation fee must accompany application.

We accept: Checks payable to TymeSavers (\$25 fee if bounced)

- VISA
- MasterCard
- Discover
- American Express

Card Number _____

Expiration Date: (month/year) ____/____

Name _____ Signature: _____

By signing, you authorize TymeSavers to charge your account for affiliation fees and/or services provided. All membership fees are non-refundable, non-transferable, and are subject to change without notice.

VI.

Applicant Acknowledgement

I acknowledge that all information provided here is accurate and truthful to the best of our knowledge.

Name _____

Signature _____

Date _____

TymeSavers, LLC
5701 East Circle Drive Ste 175
Syracuse, NY 13039
(315) 883-7470 / Fax: (315) 452-3361

