



FORM D: CHANGE TO AGENCY INFORMATION

Agency Name _____
 Agency # _____ Date _____

Please check the following changes that you will be making to your agency file. Please note that only the primary contact person can make changes to this information.

Agency Name		Distribution Address		Billing Address	
Mailing Address		Agency Phone		Contact Name	
Contact Person Phone		Contact Email		Agency Fax	
Type of Program		Services Provided		Program Schedule	
Authorized Individuals		Population Served		Website/Homepage	

Please indicate all new information on the lines provided below:

Additional Comments/Information

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Please list authorized food distribution program personnel:

NAME	TITLE/FUNCTION
1	
2	
3	
4	

By signing this you are certifying that you are authorized to make changes to the agency account.

Signature

Printed Name

Title

Date

FOR OFFICE USE ONLY

Date Information Entered into Navision	_____
FSF Team Member Who Processed Information	_____