

Medidata Solutions, Inc.
CUSTOMER VERIFICATION FORM

BUSINESS CONTACT INFORMATION

Name & Title		Date business commenced	
Company name		<input type="checkbox"/> Sole proprietorship	
Phone Fax		<input type="checkbox"/> Partnership	
E-mail		<input type="checkbox"/> Corporation	
Registered company address City, State ZIP Code		<input type="checkbox"/> Other	

INVOICE DELIVERY INFORMATION

AP Contact Name		AP Contact Name (Second)	
Title		Title	
Phone		Phone	
Fax		Email	
E-mail		Preferred Method of Delivery	<input type="checkbox"/> Email <input type="checkbox"/> Postal <input type="checkbox"/> Other

OTHER INFORMATION

Tax Status	<input type="checkbox"/> Exempt <input type="checkbox"/> Non-Exempt <input type="checkbox"/> Self-Report	Phone	
Payment Terms		E-mail	
Purchase Order Necessary	<input type="checkbox"/> Yes <input type="checkbox"/> No	Other	
Contact Name for PO's			

SIGNATURES

Signature		Signature	
Name and Title		Name and Title	
Date		Date	