



InnovationCenter
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APPLICATION FOR SERVICES

For: Resident/Affiliate
Virtual/InnoHopper Pass





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PERSONAL INFORMATION	
YOUR NAME:	
SPOUSE NAME: (IF APPLICABLE)	
PERMANENT ADDRESS:	
HOME PHONE:	
CELL PHONE:	
PERSONAL / HOME EMAIL:	
COMPANY INFORMATION	
COMPANY NAME:	
COMPANY ADDRESS:	
OTHER KEY EMPLOYEES NAMES:	
COMPANY PHONE:	
COMPANY FAX:	
COMPANY EMAIL:	
COMPANY WEBSITE:	
INDUSTRY CLUSTER:	
	Bio-technology/Bio-medical Integrating Technology Telecommunications Information Technology/Internet Advanced Manufacturing Other (please specify: _____)



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APPLICATION	
1. HAS THE BUSINESS BEEN INCORPORATED?	<input type="checkbox"/> YES <input type="checkbox"/> NO
2. IF YES, WHAT STRUCTURE HAVE YOU CHOSEN?	<input type="checkbox"/> SOLE PROPRIETORSHIP <input type="checkbox"/> LLC <input type="checkbox"/> C CORPORATION <input type="checkbox"/> S CORPORATION <input type="checkbox"/> PARTNERSHIP <input type="checkbox"/> OTHER
3. HAVE YOU GENERATED ANY SALES:	<input type="checkbox"/> YES <input type="checkbox"/> NO
4. IF YES, ANNUAL SALES IN DOLLARS?	\$ _____ .00
5. IF YES, WHEN WAS YOUR FIRST SALE MADE:	
6. ARE YOU WORKING FULL OR PART-TIME ON YOUR BUSINESS?	<input type="checkbox"/> FULL-TIME <input type="checkbox"/> PART-TIME
7. HOW DID YOU HEAR ABOUT INNOVATION CENTER?	<input type="checkbox"/> WORD OF MOUTH <input type="checkbox"/> INTERNET <input type="checkbox"/> NEWSPAPER <input type="checkbox"/> MAGAZINE <input type="checkbox"/> PSA <input type="checkbox"/> REFERRAL IF REFERRAL BY WHOM? _____
8. DATE YOU WISH TO BEGIN AFFILIATION WITH THE IC?	



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9. IN THE SPACE BELOW, PLEASE DESCRIBE YOUR BUSINESS OR CONCEPT, PRODUCT AND SERVICE?

Empty response area for describing business or concept.



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10. LIST, IN ORDER OF IMPORTANCE, WHAT TYPES OF BUSINESS SERVICES, YOU WISH TO RECEIVE.

1. _____

2. _____

3. _____

4. _____

5. _____

CREDIT REFERENCES

11. PLEASE PROVIDE THREE (3) INDIVIDUAL AND ONE BUSINESS CREDIT REFERENCES WITH CONTACT INFORMATION. INDIVIDUAL REFERENCES SHOULD BE FOR THE TEAM MEMBER NAMED IN CREDIT CARD SECTION.

1. _____

2. _____

3. _____

4. _____



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NOTES

1. Credit cards (or cashiers check or money orders in advance) are the only acceptable forms of payment.
2. All payments are billed quarterly and in advance of the services received.
3. Access to Innovation Center is by appointment/reservation during normal working hours.
4. Additional Conference Room rental is at preferred rates and must be approved by Innovation Center Staff.
5. Use of Conference Rooms, Information Island, and NIIC staff based on availability and requires advance notice.
6. Termination will occur only on the 1st of the month. Service cannot be pro-rated. Termination of these services will occur only upon written request to the NIIC staff by the affiliate.
7. Termination of these services will occur with a credit card decline notification.

AUTHORIZATION AND PAYMENT INFORMATION

I HEREBY AUTHORIZE THE INNOVATION CENTER TO USE THE FOLLOWING CREDIT CARD TO BE CHARGED ON A MONTHLY BASIS (IN ADVANCE) FOR MY AFFILIATE MEMBERSHIP BASED ON THE AFFILIATE PLAN INDICATED ABOVE.

METHOD OF PAYMENT	<input type="checkbox"/> VISA <input type="checkbox"/> DISCOVER <input type="checkbox"/> MASTERCARD <input type="checkbox"/> AMERICAN EXPRESS
CREDIT CARD #	
EXPIRATION DATE	
BILLING ADDRESS & ZIP CODE	
SOCIAL SECURITY #	
PRINT NAME AS SHOWN ON CREDIT CARD:	

Signature: _____ Date: _____