VENDOR WORKERS' COMPENSATION WAIVER FORM

We are required to maintain verification regarding workers' compensation coverage for all of our vendors that are contracted to provide a service and to release the City of Novi of any and all liability for injuries that may occur while conducting business for the City on City of Novi property or other properties.

1) Name of Vendor: (Must match the W-9 form) _____

2) Federal Tax Identification Number (or last 4 digits of Social Security No.) _____

3) Number of Employees: _____

4) _____ **I DO carry Worker's Compensation Insurance.** ***Please attach a current Certificate of Insurance that displays workers' compensation coverage for the period of time the services will be performed for the City.***

5) _____ **I DO NOT carry Worker's Compensation Insurance. Please fill out the bottom half of this form**

Please complete the following if you DO NOT have Workers' Compensation Insurance.
Signature must be witnessed by 1) City of Novi Employee, or 2) Notary Public

In consideration of the work I am performing for the City of Novi and/or it's departments and affiliates; and in lieu of required Workers' Compensation insurance, I hereby release and discharge, the City of Novi, its Mayor, Council Members, Employees and Agents, from all liability to the undersigned, his/her personal representatives, employees, assigns, heirs and next of kin, for any and all loss or damage, and any claim or demand based on injury to myself or my employee(s) that might occur while doing the work as agreed. I agree to be solely responsible for my own, and my employee(s) medical expenses.

Signature: _____ Date: _____
(to be signed in presence of City of Novi employee witness or notary)

*Parent's Signature: _____ Date: _____
***parent signature required if Vendor is under 18 years of age**

WITNESS (FIRST OPTION):

City of Novi Employee Witness Signature: _____ Date: _____

City of Novi Employee Witness Printed Name: _____

WITNESS (SECOND OPTION):

STATE OF MICHIGAN, COUNTY OF _____

On this _____day of _____, _____before me personally appeared

_____, who being duly sworn did state that s/he is not entitled to workers' compensation benefits as indicated under Michigan's Law.

Seal/Stamp

_____

Notary Public, _____County

My Commission expires_____