STATE OF CALIFORNIA
VENDING FACILITY APPLICATION
DR 462 (Rev. 07/07)

DEPARTMENT OF REHABILITATION
BUSINESS ENTERPRISES PROGRAM

Facility Number:	**Central Office BEP Use Only**
Facility Name:	Post Mail Date: _____
Facility Address:	FAX Date: _____
	Closing Date: _____

Applicant Name (Please Print):

Applicant Mailing Address:

Home Phone:	Business Phone:	Email Address:

Please answer the following questions:

1. I have operated my present facility for at least 183 calendar days.
   ☐ Yes ☐ No

2. I do not have delinquent Vendor's Monthly Operating Reports or owe delinquent fees, penalties, or insurance payments to BEP.
   ☐ Yes ☐ No

3. I am applying to operate this facility as:
   ☐ An interim vending facility. (Applicable only if vending facility is announced as an interim vending facility.)
   ☐ A primary vending facility only.
   ☐ A satellite to be added to an existing vending facility.

4. I understand that if selected, the information provided in this application is subject to verification by BEP. I further understand that information provided in my resume and statements made during my interview are subject to verification by the contracting agency. If the information is incorrect, I may be disqualified and the facility will be offered to another applicant.

Applicant Signature:	Date:
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