



IVS Partnership Program Application Form

Please fill in the application form.

Company information

Company Name: _____

Address: _____

City: _____ State/Province: _____

Zip code: _____ Country: _____

Phone: _____ Fax: _____

Contact Name: _____

Title: _____

Email: _____ Web Site: _____

IVS Partnership program (Check one)

Distributor

Lead Referral

Brief Description about your Company:

Number of Employees: _____

Years in Business: _____

Annual Revenue: _____

Estimated # of Licenses _____
(within a year)

Geographical Regions:

Target Market:

Signature of Authorized person

Date

Name of Authorized Person

Title