

## Suggested CSAB Billing Account Agency Structure Format

Date: \_\_\_/\_\_\_/\_\_\_

Agency Head Name: \_\_\_\_\_

Agency Name: \_\_\_\_\_

Agency Billing Email: \_\_\_\_\_

Agency Head Signature: \_\_\_\_\_

**Agency Head:** by signing this agreement you are consenting to be responsible for the VPN charges associated with each of the VPN accounts listed below.

Please send this completed form to [apd.wsc.vpn@apdcares.org](mailto:apd.wsc.vpn@apdcares.org)

	Treating WSC Name (must match current VPN account)	VPN User Name	WSC Email	WSC Phone Number
1				
2				
3				
4				
5				
6				
7				
8				
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12				
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