STATE OF MARYLAND
MARYLAND DEPARTMENT OF HEALTH
COMPTROLLER'S VERIFICATION FORM

DATE:

TO:

AGENCY: COMPTROLLER'S OFFICE
PHONE: (410) 767-1908
FAX #: (410) 333-7499

FROM:
FAX #:
VOICE TELEPHONE #:

MESSAGE: PLEASE PROVIDE THE REQUESTED INFORMATION REGARDING:

Name:
Address:
FEIN/SSN:

FOR USE BY THE COMPTROLLER'S OFFICE

Is this firm registered to do business in Maryland: ☐ Yes ☐ No
As a ☐ Foreign / ☐ Domestic corporation?

Are there any existing tax liabilities: ☐ Yes ☐ No

Notes:

Firm's Resident Agent:

Comptroller's Office Control Number:

THIS INFORMATION MAY BE RETURNED ELECTRONICALLY TO: _____
THANK YOU FOR YOUR ASSISTANCE.

(Additional Pages to Follow)