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VERFICATION OF "MINORITY OWNED BUSINESS", "FEMALE OWNED BUSINESS", OR "DISABLED OWNED BUSINESS" STATUS

____ verifies that it **DOES** meet the
(Firm Name)
requirements to be classified as:

[***Note: Please select either (A) or (B)***]

(A) Please select all that applies:

______ "**Minority Owned Business**" as defined as Illinois Statute 30-ILCS-575 Business Enterprise for Minorities, Females, and Persons with Disabilities Act.

______ "**Female Owned Business**" as defined as Illinois Statute 30-ILCS-575 Business Enterprise for Minorities, Females, and Persons with Disabilities Act.

______ "**Disabled Owned Business**" as defined as Illinois Statute 30-ILCS-575 Business Enterprise for Minorities, Females, and Persons with Disabilities Act.

OR

(B) If not applicable:

______ **DOES NOT** meet the requirements to be classified as "**Minority, Female or Disabled Owned Business**" as defined as Illinois Statute 30-ILCS-575 Business Enterprise for Minorities, Females, and Persons with Disabilities Act.

____ ____________________
Signature Date

____
Title