STATE COMPENSATION INSURANCE FUND
SAFETY AND HEALTH SERVICES
SAFETY MATERIALS ORDER FORM
STATE CONTRACT SERVICES

Date:

	Ship To:
State Agency Name:	
Agency Code:	
Address:	
City:	
Zip Code:	
Contact Person:	
Requested by:	(Signature)
Tel. No.:	
Email Address:	

Please print and send completed form and check to:
State Compensation Insurance Fund
303 Second Street, Suite 205 South
San Francisco, CA 94107
Attn: Safety Materials Coordinator

Payment Details
Check Enclosed:

Check No.: _____

**Amount: _____

**Note: The minimum is $50.00 per order.

PLEASE LIST ITEMS IN SCIF NUMERICAL ORDER

SCIF #	Title	Quantity	**Warehouse use only** Quantity Delivered
	*Total Quantity	____	

Total Cost: * Total Quantity ___ x $1.00 = $ ____ (Total amount of check to be issued)

For office use only:

DISTRICT/DISTRICT MANAGER	DATE	SUPPLY	DATE