**SECTION VII: Application Forms**

The following forms are also available in WORD Format for applicant use during the application period; the forms are available in a separate file that is posted in the same locations as the RFP.

**REQUEST FOR PROPOSAL COVER SHEET**

**State of Connecticut – Department of Public Health**

**Tobacco Control Program**

**RFP DPH LOG # 2025-0901**

**CONNECTICUT QUITLINE SERVICES**

**Applicant Information Form**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Legal Name FEIN

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City/Town State Zip Code

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone No. FAX No. E-Mail Address

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Person Title

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone No. E-Mail Address

**TOTAL PROGRAM COST:** $\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I certify that to the best of my knowledge and belief, the information contained in this application is true and correct. The application has been duly authorized by the governing body of the applicant, the applicant has the legal authority to apply for this funding, the applicant will comply with applicable state and federal laws and regulations, and that I am a duly authorized signatory for the applicant.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Authorizing Official: Date Typed Name and Title

-----------------------------------------------------------------------------------------------------------------------------------------------------The applicant agency is the agency or organization, which is legally and financially responsible and accountable for the use and disposition of any awarded funds.

Please provide the following information:

1. Full legal name of the organization or corporation as it appears on the corporate seal and as registered with the Secretary of State; Federal Employment Identification Number (FEIN).
2. Mailing address;
3. Main telephone number; Fax number, and email address;
4. Principal contact person for the application (person responsible for developing application), Title, Contact Information: Telephone, Email address;
5. Total program cost

The funding application and all required submittals must include the signature of an officer of the applicant agency who has the legal authority to bind the organization. The signature, typed name, and position of the authorized official of the applicant agency must be included as well as the date on which the application is signed.

**Applicant Information Form (continuation)**

*PLEASE LIST THE AGENCY CONTACT PERSONS RESPONSIBLE FOR COMPLETION AND SUBMITTAL OF:*

**Contract and Legal Documents/Forms:**

|  |  |  |
| --- | --- | --- |
|  |  |  |
|  **Name** |  **Title** |  **Tel. No.** |
|  |  |  |
|  **Street** |  **Town** |  **Zip Code** |
|  |  |
|  **Email** |  **Fax No.** |

**Program Progress Reports:**

|  |  |  |
| --- | --- | --- |
|  |  |  |
|  **Name** |  **Title** |  **Tel. No.** |
|  |  |  |
|  **Street** |  **Town** |  **Zip Code** |
|  |  |
|  **Email** |  **Fax No.** |

**Financial Expenditure Reporting Forms:**

|  |  |  |
| --- | --- | --- |
|  |  |  |
|  **Name** |  **Title** |  **Tel. No.** |
|  |  |  |
|  **Street** |  **Town** |  **Zip Code** |
|  |  |
|  **Email** |  **Fax No,** |
| **Incorporated: [ ] YES [ ] NO** | **Agency Fiscal Year:** |  |
|  |
| **Type of Agency: [ ]  Public [ ]  Private [ ]  Other, Explain:** |  |
|  |  |
|  **[ ]  Profit [ ]  Non-Profit**  |  |
| **Federal Employer I.D. Number:** |  | **Town Code No:** |  |
| **Medicaid Provider Status: [ ] YES [ ] NO** | **Medicaid Number:** |  |
| **Minority Business Enterprise (MBE): [ ] YES [ ] NO**  |
| **Women Business Enterprise (WBE): [ ] YES [ ] NO**  |

**PROPOSAL OUTLINE**

**Provided as a courtesy to facilitate Table of Contents and clarify proposal organization.**

**COVER SHEET**

**APPLICATION INFORMATION FORM**

**TABLE OF CONTENTS**

**EXECUTIVE SUMMARY**

**MAIN PROPOSAL: NARRATIVE – Note this narrative is restricted to 25 pages**

**Organizational Profile**

Purpose, Mission, Vision, Values

Entity Type / Parent Organization / Years of Operation

Location of Offices / Call Facilities

Functional Organization

Current Range of Services /Clients

Qualifications: Strengths and Qualifications of Agency & Staff

Relevant Experience

Accreditation / Certification / Licensure

Governance System

References: Three references with Contact Information

**Scope of Services**

Community Collaboration and Engagement

 Service Capacity / Delivery Plan/Systems / Processes / Protocols

Client Engagement/Consultation /Evaluation/Treatment Plan

Quality Assurance Protocols

Administrative Support

Special Health or Safety Requirements

**Staffing Plan**

Key Personnel / Managers

Staffing Levels & Qualifications

Job Descriptions

Personnel Organization Chart

Point of Contact Identified

Recruitment, Hiring & Retention Plan

Staff Training / Education / Development

Hours of Operation & Hours of Service Provision

**Data and Technology**

E-Mail / Internet Capabilities

IT Infrastructure / Hardware/Software Quality

Data Collection / Storage

Reporting Capability

Methods of Communication

Assessment of Client Satisfaction

Evaluation / Outcome Measures

**Subcontractors**

Legal Name of Agency, Address, FEIN

Contact Person, Title, Phone, Fax, E-mail

Services Currently Provided

Services to Be Provided Under Subcontract

Subcontractor Oversight

Subcontract Cost and Term

**Financial Profile**

Annual Budget and Revenues

 Financial Standing

 Financial Management Systems

 Revenue Generation/Billing/Third Party Reimbursement

**MAIN PROPOSAL: NARRATIVE – Continued**

**Work Plan**:

Within the project proposal narrative, include a quick summary of the overall work plan, the details will be provided in the form included in the Application Forms

**Declaration of Confidential Information:**

**Conflict of Interest – Disclosure Statement**

**[END OF MAIN PROPOSALNARRATIVE SECTION – with the 25 Page Restriction]**

**FORM: Statement of Assurances**

**FORMS: Budget Summary and Justification**

 Fee for Service Line Items

 Subcontractor Detail

 Staffing Profile

**FORM: Work Plan** (Use as many pages as needed)

**SAMPLE PARTICIPANT MATERIALS –** include both Adult and Youth materials as well as a specialty/ subpopulation

such as pregnant women or lesbian, gay, bisexual, transgender

**SAMPLE REPORTS** PROVIDED WEEKLY/MONTHLY/QUARTERLY/ANNUALLY

Quitline Services Division **Organizational Chart**

**Résumés** of Key Personnel

Any additional attachments proposers feel will add clarification of their proposal.

**FORM**: Applicant Capability Chart

**FORM**: Tobacco Industry Funding and Partnership Certification

**FORM**: Notification to Bidders Form acknowledgement of receipt

**FORM**: Workforce Analysis Form for any employees located in Connecticut .

**IRS Determination Letter** (for nonprofit proposers)

**Audited Financial Statements .** .

**Call Recordings** (3) for intake/registration, initial assessment/counseling and follow-up counseling calls.

 . . . . . . . . .

1. **BUDGET SUMMARY AND JUSTIFICATION: Fee for Service Budget**

Please provide an explanation for each line item listed on the budget summary form and include a detailed breakdown of the components that make up the line item and any calculation used to compute the amount.

|  |  |  |  |
| --- | --- | --- | --- |
| **Line Item (Description)** | **Amount per Unit** | **Total for Line Item** | **Justification including Breakdown of Costs** |
|       |       |       |       |
|       |       |       |       |
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|       |       |       |       |
| **Total Budget:** |       |  |

1. **Budget Justification – Subcontractor Schedule Instructions**
	1. For contractors who have subcontracts, a brief description of the purpose of each subcontract must be provided. All subcontractors used by each program must be included, if it is not known who the subcontractor will be, an estimated amount and whatever budget detail is anticipated should be provided. (Submit the actual detail when it is available). A separate subcontractor schedule must be completed for each program included in the contract.

*For example: The contract is providing both a Needle Exchange program and an AIDS Prevention Education Program and Subcontractor “A” is providing services to both program there must be a separate budget for Subcontractor “A” for each.*

* 1. Detail of Each Subcontractor:
		1. Choose a category below for each subcontract using the basis by which it is paid:

[ ]  A. Budget Basis [ ]  B. Fee for Service [ ]  C. Hourly Rate.

* + 1. Choose whether the subcontractor is a minority or woman owned business:

[ ]  MBE [ ]  WBE [ ]  Neither

* + 1. Provide the detail for each subcontract just as for the primary contract budget referencing the corresponding program of the contract. Detail must be provided for each subcontractor listed in the Summary.

Note: If space allowed is not sufficient for large or complex subcontract budgets, the primary Budget Summary format may be copied and used instead.

1. **Budget Justification – Subcontractor Schedule Detail Form**

**#1**

Subcontractor Name:

Address:

Telephone: (     ) (     -     )

Select One: **A** [ ]  Budget Basis **B** [ ]  Fee-for-Service **C** [ ]  Hourly Rate

Indicate One: [ ]  MBE [ ]  WBE [ ]  Neither

|  |  |
| --- | --- |
| **Description of Services to be Provided** | **Total** |
| Line Item(s) |  |
|  |  |
|  |  |
|  |  |
|  |  |
| **Total Subcontract Amount:** |  |

**#2**

Subcontractor Name:

Address:

Telephone: (     ) (     -     )

Select One: **A** [ ]  Budget Basis **B** [ ]  Fee-for-Service **C** [ ]  Hourly Rate

Indicate One: [ ]  MBE [ ]  WBE [ ]  Neither

|  |  |
| --- | --- |
| **Description of Services to be Provided** | **Total** |
| Line Item(s) |  |
|  |  |
|  |  |
|  |  |
|  |  |
| **Total Subcontract Amount:** |  |

**#3**

Subcontractor Name:

Address:

Telephone: (     ) (     -     )

Select One: **A** [ ]  Budget Basis **B** [ ]  Fee-for-Service **C** [ ]  Hourly Rate

Indicate One: [ ]  MBE [ ]  WBE [ ]  Neither

|  |  |
| --- | --- |
| **Description of Services to be Provided** | **Total** |
| Line Item(s) |  |
|  |  |
|  |  |
|  |  |
|  |  |
| **Total Subcontract Amount:** |  |

1. **Budget Justification – Staffing Profile**

|  |  |  |  |
| --- | --- | --- | --- |
| **Position Description**  | **Staff Person Assigned** | **Site/ Location** | **Assigned to Project****# Hours wk./** **# wks. per Year** |
| 1. Position:
 | Name:       |       |      /      |
| 1. Position:
 | Name:       |       |      /      |
| 1. Position:
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| 1. Position:
 | Name:       |       |      /      |
| 1. Position:
 | Name:       |       |      /      |

**\*Attach resumes and job descriptions for all Professional Staff**

**Work Plan**

**(Make as many blank pages as needed, and form may be set up in either portrait or landscape mode)**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Services to be Provided****(Provide specifics using the pr)** | **Activities****(Tasks/Deliverables)** | **Staff Position(s) Responsible** | **Expected Outcomes,** **Measures of Success** | **Timeframe for Completion****(Include scheduled start and end dates)** |
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**Applicant Capability Chart**

To assist in assessing the capability of the applicant, the following Chart is to be completed with data from the applicant’s experience operating a Quitline. If there is no data available put “n/a” into the box.

|  |  |  |  |
| --- | --- | --- | --- |
|  | **English** | **Spanish** | **Comments** |
| **Call Standards** |  |  |  |
| % of live answer |  |  |  |
| % of abandoned after 30 seconds |  |  |  |
| % to voicemail during hours of operation |  |  |  |
| % of calls answered within 30 seconds |  |  |  |
| Average speed to answer (in seconds) |  |  |  |
| **Other Services Standards** |  |  |  |
| Time for delivery of NRT to participant from time requested |  |  |  |
| % of participants who receive NRT within your quality standard |  |  |  |
| Time of delivery of education materials to participant |  |  |  |
| # of hours Quitline operated by applicant was not fully functional in past 12 months due to weather equipment failure, software failure, etc. |  |  |  |
| # of hour online components operated by the applicant was not fully functional in past 12 months |  |  |  |
| Average # of text messages received by participants that requested them |  |  |  |
| % of participants receiving more than one pro-active coaching call  |  |  |  |
| % of participants receiving more than one pro-active coaching call who talked with the same coach at each call |  |  |  |
| Conversion rate for registration to coaching (# who completed 1st coaching session/#complete registration) |  |  |  |
| % of participants in multiple call programs receiving a time sensitive follow-up call within 48 hours of their quit date  |  |  |  |
| # of registered Quitline participants in the past 12 months (phone/online/text) |  |  |  |

State of Connecticut

Department of Public Health

Tobacco Control Program

**Tobacco Industry Funding and Partnership Certification**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_certify that \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ has not

(Printed Signatory Name) (Company/Agency)

received funding or engaged in partnerships, either formal or informal, with any Tobacco Company within the last three (3) years.

The above-mentioned agency will not accept funding nor engage in partnerships with any Tobacco Company during the contract period, should we be awarded funds from the CT Department of Public Health, Tobacco Control Program.

Applicant’s Authorized Signature Date





**NOTIFICATION TO BIDDERS**

The contract to be awarded is subject to contract compliance requirements mandated by Section 4-114a of the Connecticut General Statutes; and, when the awarding agency is the state, Section 46a-71(d) of the Connecticut General Statutes. There are Contract Compliance Regulations codified at Section 4-114a et. seq. of the Regulations of Connecticut State Agencies which establish a procedure for the awarding of all contracts covered by Sections 4-114a and 46a-71(d) of the Connecticut General Statutes.

According to Section 4-114a-3(9) of the Contract Compliance Regulations, every agency awarding a contract subject to the contract compliance requirements has an obligation to “aggressively solicit the participation of legitimate minority business enterprises as bidders, contractors, subcontractors and suppliers of materials.” “Minority business enterprise” is defined in Section 4-114a of the Connecticut General Statutes as a business wherein fifty-one percent or more of the capital stock, or assets belong to a person or persons: “(1) who are active in the daily affairs of the enterprise; (2) who have the power to direct the management and policies of the enterprise; and (3) who are members of a minority, as such term is defined in subsection (a) of Section 32-9n.” “Minority” groups are defined in Section 32-9n of the Connecticut General Statutes as “(1) Black Americans...(2) Hispanic Americans...(3) Women...(4) Asian Pacific Americans and Pacific Islanders; or (5) American Indians... ”The above definitions apply to the contract compliance requirements by virtue of Section 4-114a-1 (10) of the Contract Compliance Regulations.

The awarding agency will consider the following factors when reviewing the bidder’s qualifications under the contract compliance requirements:

1. the bidder’s success in implementing an affirmative action plan;
2. the bidder’s success in developing an apprenticeship program complying with Sections 46a-68-1 to 46a-68-17 of the Connecticut General Statutes, inclusive;
3. the bidder’s promise to develop and implement a successful affirmative action plan;
4. the bidder’s submission of EEO-1 data indicating the composition of it’s work force is at or near parity when compared to the racial and sexual composition of the work force in the relevant labor market area; and
5. the bidder’s promise to set aside a portion of the contract for legitimate minority business enterprises. See Section 4-114a-3 (10) of the Contract Compliance Regulations.

INSTRUCTION: Bidder must sign acknowledgment form below and return signed page to Awarding Agency along with bid proposal. Please retain a copy for your files.

The undersigned acknowledged receiving and reading a copy of the “Notification to Bidders” form.

 Signature Date

on behalf of:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| **WORKFORCE ANALYSIS** |
| Contractor Name: | Total Number of CT employees: |
| Address: | Full Time: | Part Time: |
|  |  |
| Complete the following Workforce Analysis for employees on Connecticut worksites who are: |
| Job Categories | Overall Totals(sum of all cols. male & female) | White(not of Hispanic Origin) | Black(not of Hispanic Origin) | Hispanic | Asian or Pacific Islander | American Indian or Alaskan Native | People withDisabilities |
|  | Male | Female | Male | Female | Male | Female | Male | Female | Male | Female | Male | Female |
| Officials &Managers |  |  |  |  |  |  |  |  |  |  |  |  |
| Professionals |  |  |  |  |  |  |  |  |  |  |  |  |
| Technicians |  |  |  |  |  |  |  |  |  |  |  |  |
| Office &Clerical |  |  |  |  |  |  |  |  |  |  |  |  |
| Craft Workers(skilled) |  |  |  |  |  |  |  |  |  |  |  |  |
| Operatives(semi-skilled) |  |  |  |  |  |  |  |  |  |  |  |  |
| Laborers(unskilled) |  |  |  |  |  |  |  |  |  |  |  |  |
| Service Workers |  |  |  |  |  |  |  |  |  |  |  |  |
| Totals Above |  |  |  |  |  |  |  |  |  |  |  |  |
| Totals 1 year Ago |  |  |  |  |  |  |  |  |  |  |  |  |
| FORMAL ON-THE-JOB TRAINEES (Enter figures for the same categories as are shown above) |
| Apprentices |  |  |  |  |  |  |  |  |  |  |  |  |
| Trainees |  |  |  |  |  |  |  |  |  |  |  |  |
| EMPLOYMENT FIGURES WERE OBTAINED FROM: | Visual Check: | Employment Records | Other: |
|  |
| 1. Have you successfully implemented an Affirmative Action Plan? [ ]  YES [ ]  NO Date of implementation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If the answer is “No”, explain.1. a) Do you promise to develop and implement a successful Affirmative Action? [ ]  YES [ ]  NO [ ]  Not Applicable Explanation:2. Have you successfully developed an apprenticeship program complying with Sec. 46a-68-1 to 46a-68-18 of the Connecticut Department of Labor Regulations, inclusive: [ ]  YES [ ]  NO [ ]  Not Applicable Explanation: |
| 3. According to EEO-1 data, is the composition of your work force at or near parity when compared with the racial and sexual composition of the work force in the relevant labor market area? [ ]  YES [ ]  NO Explanation: |

4. If you plan to subcontract, will you set aside a portion of the contract for legitimate minority business enterprises?

 [ ]  YES [ ]  NO Explanation:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Authorized Signature Date

**STATEMENT OF ASSURANCES**

Department of Public Health

Tobacco Control Program

The undersigned Respondent affirms and declares that:

1) General

1. This proposal is executed and signed with full knowledge and acceptance of the RFP CONDITIONS stated in the RFP.
2. The Respondent will deliver services to the Agency for the cost proposed in the RFP and within the timeframes therein.
3. The Respondent will seek prior approval from the Agency before making any changes to the location of services.
4. Neither the Respondent of any official of the organization nor any subcontractor the Respondent of any official of the subcontractor organization has received any notices of debarment or suspension from contracting with the State of CT or the Federal Government.
5. Neither the Respondent of any official of the organization nor any subcontractor to the Respondent of any official of the subcontractor’s organization has received any notices of debarment or suspension from contracting with other states within the United States.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Legal Name of Organization

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorized Signatory Date