REQUEST FOR PROPOSAL
RFP # DOC-PHARMACY SERVICES RFP2018
Department of Correction
October 2018

FORM #6: Proposal Cover Sheet

Applicant Name _____ **FEIN** _____

Address _____

City/Town _____ **State** _____ **Zip Code** _____

Agency Contact:
Title: _____ _____

Telephone Number _____ **E-Mail Address** _____ **Fax Number** _____

Applicant Fiscal Year: _____ to _____
(Month) (Month)

Is your agency a non-profit? Yes ☐ No ☐ **Is your agency incorporated?** Yes ☐ No ☐

Is your agency registered as a:
Minority Business Enterprise? Yes ☐ No ☐
Women Business Enterprise? Yes ☐ No ☐
Small Business Enterprise? Yes ☐ No ☐

Certification:
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 _____