**VENDOR’S ORGANIZATION QUESTIONNAIRE/AFFIDAVIT AND CBE INFORMATION**

Please complete, date and sign this form. The person signing the form must be authorized to sign on behalf of the Respondent and to bind the applicant to the Master Agreement.

1. If your firm is a corporation or limited liability company (LLC), state its legal name (as found in your Articles of Incorporation) and State ofincorporation:

|  |  |  |
| --- | --- | --- |
| **Name** | **State** | **Year Inc.** |
|  |  |  |

2. If your firm is a limited partnership or a sole proprietorship, state the name of the proprietor or managing partner:

3. If your firm is doing business under one or more DBA’s, please list all DBA’s and the County(s) of registration:

|  |  |  |
| --- | --- | --- |
| **Name** | **County of Registration** | **Yr. became DBA** |
|  |  |  |
| **Name** | **County of Registration** | **Yr. became DBA** |
|  |  |  |

**If your firm is going to use a DBA for the Master Agreement, please provide the Fictitious Business Name Statement filed with the Los Angeles County Registrar Recorder with the corresponding name.**

4. Is your firm wholly or majority owned by, or a subsidiary of, another firm?  No  Yes **If yes,**

**Name of parent firm:**

State of incorporation or registration of parent firm:

5. Please list any other names your firm has done business as within the last five (5) years.

|  |  |
| --- | --- |
| **Name** | **Yr. of Name Change** |
|  |  |
| **Name** | **Yr. of Name Change** |
|  |  |
| **Name** | **Yr. of Name Change** |
|  |  |

6. Indicate if your firm is involved in any pending acquisition/merger, including the associated company name. If not applicable, so indicate below.

Respondent acknowledges and certifies that it meets and will comply with the Minimum Qualification Requirements listed in Paragraph 2.1, Minimum Qualification Requirements, of this Request for Statement of Ancillary Services Qualifications.

**CBE INFORMATION**

1. **FIRM/ORGANIZATION INFORMATION:** The information requested below is for statistical purposes only. On final analysis and consideration of award, contractor/vendor will be selected without regard to race/ethnicity, color, religion, sex, national origin, age, sexual orientation or disability.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Business Structure:**  Sole Proprietorship  Partnership  Corporation  Non-Profit  Franchise  Other (Please Specify) | | | | | | |
| **Number of California Employees:** | | | | | | |
| **Total Number of Employees of Firm** (including owners)**:** | | | | | | |
| **Race/Ethnic Composition of Firm.** Please distribute the **total number of employees** **of Firm** into the following categories: | | | | | | |
| **Race/Ethnic Composition** | **Owners/Partners/**  **Associate Partners** | | **Managers** | | **Staff** | |
|  | Male | Female | Male | Female | Male | Female |
| Black/African American |  |  |  |  |  |  |
| Hispanic/Latino |  |  |  |  |  |  |
| Asian or Pacific Islander |  |  |  |  |  |  |
| American Indian |  |  |  |  |  |  |
| Filipino |  |  |  |  |  |  |
| White |  |  |  |  |  |  |

**II. PERCENTAGE OF OWNERSHIP IN FIRM:** Please indicate by percentage (%) how ownership of the firm is distributed.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Black/African American** | **Hispanic/ Latino** | **Asian or Pacific Islander** | **American Indian** | **Filipino** | **White** |
| Men | % | % | % | % | % | % |
| Women | % | % | % | % | % | % |

**III. CERTIFICATION AS MINORITY, WOMEN, DISADVANTAGED, AND DISABLED VETERAN BUSINESS ENTERPRISES:** *If your firm is currently certified as a minority, women, disadvantaged or disabled veteran owned business enterprise by a public agency, complete the following and attach a copy of your proof of certification. (Use back of form, if necessary.)*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Agency Name** | **Minority** | **Women** | **Disadvantaged** | **Disabled Veteran** | **Other** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

Respondent further acknowledges that if any false, misleading, incomplete, or deceptively unresponsive statements in connection with this proposal are made, the proposal may be rejected. The evaluation and determination in this area shall be at the Director’s sole judgment and his/her judgment shall be final.

**DECLARATION: I DECLARE UNDER PENALTY OF PERJURY UNDER THE LAWS OF THE STATE OF CALIFORNIA THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE.**

|  |
| --- |
| **Respondent’s Name** |
|  |
| **Address** |
|  |

|  |  |  |
| --- | --- | --- |
| **E-mail address:** | **Telephone number:** | **Fax number:** |
|  | - - | - - |

On behalf of (Respondent’s name), I (Name of Respondent’s authorized representative), certify that the information contained in this Respondent’s Organization Questionnaire/Affidavit is true and correct to the best of my information and belief.

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

Signature

|  |  |  |
| --- | --- | --- |
| **Title** | | **CA Secretary of State**  **Entity Numbe**r |
|  | |  |
| **Date** | **IRS Employer Identification Number** | **County WebVen Number** |
|  |  |  |

**MINIMUM QUALIFICATIONS REQUIREMENT VERIFICATION**

Instructions:

Fill in Respondent’s Legal Business Name as indicated, answer “Yes” or “No” next to each minimum qualification that represents your firms status, and the provide signature of the authorized signatory for your firm, below. Any Respondent not meeting the Minimum Qualifications will be disqualified.

As an authorized representative of (Respondent's Legal Business Name Here), I affirm that (Respondent's Legal Business Name Here) meets the following minimum qualifications.

|  |  |
| --- | --- |
| **MINIMUM QUALIFICATIONS REQUIREMENT** | **CHECK ONE** |
| My firm has a minimum of 3 consecutive years' experience in the last 5 years providing Intraoperative Neurophysiological Monitoring Services, (including Intraoperative EP Monitoring, SSEP Spinal Cord Monitoring, Intraoperative EEG Monitoring, Electrocorticography/Motor Strip Mapping) for large hospitals/medical centers.  Date business started: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |
| **-OR-** |  |
| My firm is an existing DHS Contractor in good standing with a Board of Supervisors approved Service Agreement for Intraoperative Monitoring Services |  |

I affirm I am an authorized signatory of (Respondent's Legal Business Name Here), and that my firm meets the Minimum Qualifications Requirement affirmed with a “Yes” above.

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

Signature Date

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

Printed Name and Title

**PROSPECTIVE CONTRACTOR REFERENCES**

**Respondent’s Name:**

The Respondents must provide three (3) references where the same or similar scope of services were provided. It is the Respondents’ sole responsibility to ensure that the firm’s name, and point of contacts name, title, phone and e-mail address for each reference is accurate.

|  |  |  |
| --- | --- | --- |
| 1. **Name of Firm:** | **Address of Firm:** | **Contact Person:** |
| **Telephone #:**  - - | **E-mail Address:** | **Specific Date of Contract – From - To**  - - - - - |
| **Name or Contract No.** | **Type of Service:** | **Annual Dollar Amount:**  $ |
|  | | |
| **2. Name of Firm:** | **Address of Firm:** | **Contact Person:** |
| **Telephone #:**  - - | **E-mail Address:** | **Specific Date of Contract – From - To**  - - - - - |
| **Name or Contract No.** | **Type of Service:** | **Annual Dollar Amount:**  $ |
|  | | |
| 1. **Name of Firm:** | **Address of Firm:** | **Contact Person:** |
| **Telephone #:**  - - | **E-mail Address:** | **Specific Date of Contract – From - To**  - - - - - |
| **Name or Contract No.** | **Type of Service:** | **Annual Dollar Amount:**  $ |