**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.

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**Signature of Authorizing Official Date**

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**Typed Name and Title**