# ATTACHMENT 2

## CERTIFICATIONS

**(MANDATORY SUBMISSION: to be completed and included in the solicitation documents)**

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| **RFQual22-03 – INDEPENDENT MEDICAL EXAMINER SERVICES** |
| 1. **Information with regard to the Physician**
 |
| 1. **Provide the Physician’s name, address, and telephone number.**
 |
| **Name:**  |
| **Address:**  |
| **City, State, ZIP Code:**  |
| **Telephone Number (including area code):**  |
| **Physician’s Taxpayer Identification Number:** |
| **Physician’s New York State Vendor Identification Number:** |
| 1. **Provide the name, address, telephone number, and email address of the Physician’s Primary Contact with regard to this solicitation.**
 |
| **Name:**  |
| **Address:**  |
| **City, State, ZIP Code:**  |
| **Telephone Number (including area code):**  |
| **Email Address:**  |
| 1. **Provide the name, address, telephone number, and email address of the entity to whom payment will be made:**
 |
| **Name:** |
| **Address:** |
| **City, State, ZIP Code:** |
| **Telephone Number (including area code):** |
| **Email Address:** |
| **Taxpayer Identification Number:** |
| **New York State Vendor Identification Number:** |
| 1. **In accordance with paragraph 6 of the OSC Procurement Integrity Procedures included in this solicitation as Appendix D, provide the name, address, telephone number, email address, place of principal employment and occupation of any person authorized to represent the Physician. This requirement applies not only to Physician’s employees involved in the submission of the solicitation, but also to every individual or organization employed or designated by the Physician to attempt to influence the procurement process. If there is none, state that. This information must be updated if, after the Deadline for Submissions, the Physician retains an individual or organization to attempt to influence the procurement process. Indicate also whether the individual or organization has a financial interest in the procurement.**
 |
| **Name:**  |
| **Address:**  |
| **City, State, ZIP Code:**  |
| **Telephone Number (including area code):**  |
| **Email Address:**  |
| **Place of Principal Employment:**  |
| **Occupation:**  |
| **This individual/organization has a financial interest in the procurement:** |  |
| **No such individual/organization is authorized to represent the Physician:** |  |
| 1. **Minimum Qualifications:**
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| 1. **The Physician is licensed to practice medicine in New York State.**
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| 1. **The Physician is Board Certified in at least one of the specialties or subspecialities listed in the New York State Contract Reporter Advertisement.**
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| 1. **The Physician confirms that they do not have any professional misconduct proceedings pending against them and has not been found guilty previously of any misconduct.**
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| 1. **The Physician is able to provide medical facilities that are accessible to persons with disabilities and are suitable for conducting a medical examination.**
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| 1. **The Physician has sufficient proficiency in English, both verbal and written, to provide the Services.**
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| 1. **Physician’s Acknowledgement of Submission Requirements:**

**[Please note: alteration of any language contained in this section may render your submission non-responsive.]** |
| 1. **The submission constitutes a firm and irrevocable offer for a period of 180 days from the date of submission to OSC.**
 |  |
| 1. **The Physician agrees to fully comply with the OSC Executive Order on Procurement Integrity and the OSC Procurement Integrity Procedures attached to this solicitation as Appendix D.**
 |  |
| 1. **The Physician certifies that they can and will provide and make available, at a minimum, all services as described in the Draft Contract if selected for award.**
 |  |
| 1. **The Physician certifies that they can schedule appointments in accordance with Section VII of the Draft Contract.**
 |  |
| 1. **The Physician certifies that they possesses the necessary integrity and professional capacity to meet OSC’s reasonable expectations. Subsequent to the commencement of Services, whenever the Physician becomes aware, or reasonably should have become aware, that any staff member(s) providing Services to OSC no longer possesses the necessary integrity or professional capacity, the Physician agrees to immediately discontinue the use of such staff and notify OSC.**
 |  |
| 1. **The Physician certifies that all information provided in connection with its submission is true and accurate.**
 |  |
| 1. **The Physician has read, understands, and accepts all provisions of Appendix A – Standard Clauses for New York State Contracts. Appendix A contains important information related to the contract to be entered into as a result of this solicitation and will be incorporated, without change or amendment, into the contract entered into between OSC and the selected Physician. By submitting a response to the RFQual, the Physician agrees to comply with all the provisions of Appendix A.**
 |  |
| 1. **The Physician’s Legal representation has reviewed and understands the Draft Contract, and the Physician is willing to enter into an Agreement substantially in accord with the terms of the Draft Contract, including Attachment 1, the Fee Schedule, should the Physician be selected for contract award.**
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| 1. **The Physician agrees that they shall be fully responsible for performance of work by their staff and subcontractor’s staff.**
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| **\* A “No” Response in Sections 2 or 3 of this attachment will result in disqualification.** |
| 1. **Information Required:**
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| 1. **The Physician is (check all applicable):**
 |
| **A New York State Certified Minority-Owned Business Enterprise****A New York State Certified Woman-Owned Business Enterprise****A New York State Service Disabled Veteran-Owned Business** **None of the above** |
| 1. **Provide the name, title, address, telephone number, and email address of the person authorized to receive notices with regard to the contract entered into as a result of this solicitation. See Section VII of the Draft Contract, NOTICES.**
 |
| **Name:** |
| **Title:** |
| **Address:** |
| **City, State, ZIP Code:** |
| **Telephone Number (including area code):** |
| **Email Address:** |
| **By my signature on this Attachment B, I certify that I am authorized to bind the Physician contractually.** |
| **Typed or Printed Name of Authorized Representative of the Physician** |
| **Title/Position of Authorized Representative of the Physician** |
| **Signature of Authorized Representative of the Physician** |
| **Date** |
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