

**ACCREDITATION APPLICATION FORM**

**For the Provision of**

**Primary Care Locally Commissioned Public Health Services (LCPHS)**

**General Practitioners (GP)**

**REFERENCE: CPU 3533**

**ACCREDITATION QUESTIONNAIRE**

This application form will be used by Nottingham City Council (“the Council”) in deciding which General Practitioners (Providers) will be awarded a contract to deliver Locally Commissioned Public Health Services (LCPHS) from 1 April 2022 for three years with potential contract extensions of a further 3+3 years.

Applicants must be explicit and comprehensive in their responses to this Questionnaire as this will be the single source of information on which their responses will be assessed. Applicants are advised neither to make any assumption about their past or current supplier relationships with the Council, nor to assume that such prior business relationships will be taken into account in the evaluation procedure.

* Please complete all of the sections included within this application form relevant to your application
* Questions should be answered as accurately and concisely as possible. Where a question is not relevant to your organisation, this should be indicated with an explanation.
* If you have any queries regarding how to complete this application form, please submit them via email to:- [SexualHealth@nottinghamcity.gov.uk](mailto:SexualHealth@nottinghamcity.gov.uk)

You may be asked to clarify your answers, or provide more details. If questions are not applicable, please state ‘**not applicable’**; and state the **reason why** the question is ‘not applicable’.

**Completed applications must be submitted via email to:-**

[SexualHealth@nottinghamcity.gov.uk](mailto:SexualHealth@nottinghamcity.gov.uk)

**Please Note:- for continuation of service delivery and to ensure payment of invoices are authorised, existing contracted General Practitioners should ensure that they apply as soon as possible to ensure award of contract from 1 April 2022 to avoid any gaps in service delivery.**

**Evaluation Principles**

Responses to the questions in Part A & B in this Accreditation application form will be evaluated in accordance with the **Scoring Principles** detailed below.

| **Scoring Principles** | |
| --- | --- |
| **Required Data** | The data provided is for information only and will not be scored / assessed but if the information requested is not provided the bid will be judged non-compliant unless there is an acceptable reason for its omission. |
| **Pass** | The information / evidence has been assessed and judged to be acceptable. |
| **Fail** | No information / evidence has been provided.  The standard of information / evidence provided is unacceptable. |

**APPLICATION FORM**

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| **PART A – GENERAL QUESTIONS** | |
| **Licenses and Regulation** | |
| | **Scoring** | **Requirements** | | --- | --- | | Pass/Fail | Compliance with CQC requirements. Please note that failure to fulfil these requirements **will** result in the Applicant being excluded from the process. | | |
| Is your organisation / Practice registered with CQC? | Yes / No |
| If **‘Yes’**, please state the year of registration: |  |

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| **1** | **Organisation Details** | | |
| | **Scoring** | **Requirements** | | --- | --- | | Required Data | The data is required for management purposes only and will not be scored / assessed. If the information requested is not provided the bid will be judged non-compliant unless there is an acceptable reason for its omission. | | | | |
| **1.1** | Full name of organisation / Practice applying for accreditation: |  | |
| **1.2** | Registered office address: |  | |
| **1.3** | Company registration number: |  | |
| **1.4** | VAT registration number (if applicable): |  | |
| **1.5** | Full name of the GP Practice where services are to be delivered (if different to 1.1): |  | |
| **1.6** | GP Practice address (if different to 1.2): |  | |
| **1.7** | Full name of Practice / Business Manager: |  | |
| **1.8** | Contact name, job title, telephone and e-mail address for enquiries about your Application: | Name: |  |
| Job Title: |  |
| Telephone: |  |
| E-mail: |  |

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| **2** | **Business Standing** | |
| | **Scoring** | **Requirements** | | --- | --- | | Pass / Fail | The Council is entitled to eliminate your application from this accreditation process if there are concerns over your professional and business conduct. However, if you are able to give a satisfactory explanation your application may be allowed to proceed. |   **Responses marked with an asterisk (\*) may lead to your application being rejected, therefore please ensure that you provide further details where requested.** | | |
| **2.1** | Is your organisation in a state of bankruptcy, insolvency, compulsory winding up, receivership, composition with creditors, and/or subject to relevant proceedings? | Yes\* / No |
| If **‘Yes’**, confirm which and provide further details: | |
| **2.2** | Have any of the directors / partners / proprietors been convicted of a criminal offence related to business or professional conduct? | Yes\* / No |
| If **‘Yes’**, confirm which and provide further details: | |
| **2.3** | The directors / partners / proprietors of your organisation are, or have been, under suspicion or investigation by the Office of Fair Trading or have ever approached the Office of Fair Trading and made a leniency application | Yes\* / No |
| If **‘Yes’**, confirm which and provide further details: | |
| **2.4** | Have any of the directors / partners / proprietors committed an act of grave misconduct in the course of business? | Yes\* / No |
| If **‘Yes’**, state the year(s) and provide further details: | |
| **2.5** | Have any of the directors / partners / proprietors not fulfilled obligations related to payment of social security contributions? | Yes\* / No |
| If **‘Yes’**, provide further details: | |
| **2.6** | Have any of the directors / partners / proprietors not fulfilled obligations related to payment of taxes? | Yes\* / No |
| If **‘Yes’**, provide further details: | |
| **2.7** | Is your organisation in possession of all relevant licences and memberships required by law, and registered on any relevant regulatory register required by law of that state in which it is established? | Yes / No\* |
| If **‘No’**, provide further details: | |

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| **3** | **Insurance** | | | | |
| | **Scoring** | **Requirements** | | --- | --- | | Pass/Fail | You must have the appropriate insurance cover (to the levels stated in section 3 below) or confirm that such levels would be put in place prior to the contract award. Please ensure you are able to provide evidence of your policies if requested. Any Applicant that does not have the stated levels and does not agree to increase to these levels will be excluded. |   **Responses marked with an asterisk (\*) may lead to your application being rejected, therefore please ensure that you provide further details where requested.** | | | | | |
| Please indicate whether your organisation has or will have the following insurances if awarded a contract by placing an **“X”** in the appropriate box | | | | | |
| **Type of Insurance Policy:** | | **Value** | **Yes**  We have these levels of insurance at the time of completing this Questionnaire | **No**  We do not currently carry this level of insurance but will if successful. | **No\***  We will not secure required insurance. |
| **3.1** | Employer’s Liability | £5 million public liability insurance with a limit of indemnity of not less than £5 million in relation to any one claim or series of claims |  |  |  |
| **3.2** | Public Liability | £5 million employer's liability insurance with a limit of indemnity of £5 million and not less than the statutory minimum |  |  |  |
| **3.3** | Professional Indemnity | £1 million professional indemnity insurance with a limit of indemnity of not less than £1 million in relation to any one claim or series of claims and shall ensure that all professional consultants and sub-contractors involved in the provision of the Services hold and maintain appropriate cover; |  |  |  |

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| **Type of Insurance Policy:** | | | **Value** | | **Yes**  We have these levels of insurance at the time of completing this Questionnaire | | **No**  We do not currently carry this level of insurance but will if successful. | | **No\***  We will not secure required insurance. | |
| **3.4** | Cyber-Risk, please indicate that you have one of the following:    Do you hold a separate cyber-risk policy?  Or a Cyber-Essentials or Cyber-Essentials Plus certificate?  Or do you meet other recognised standards such as ISO 27001 or ISO 22301?  If not, please confirm that your existing insurances (specifically Public Liability policy) will respond to cyber-risks | | £1 million | |  | |  | |  | |

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| **4** | **Safeguarding Adults and Children at Risk** | |
| | **Scoring** | **Requirements** | | --- | --- | | Pass/Fail | All successful applicants are required to adhere to Safeguarding principles and procedures as outlined in the Nottingham City Council Safeguarding Adults procedure <https://www.nottinghamcity.gov.uk/ncaspb> and the Nottingham City Council Safeguarding Children procedure: <https://www.nottinghamcity.gov.uk/information-for-residents/children-and-families/nottingham-city-safeguarding-children-board/worried-about-a-child> In addition you are required to have your own policies for safeguarding both Adults and Children.  Further details can be found in the service specifications.  Confirmation is required as to whether all relevant staff are DBS checked. Where staff have not undergone a DBS check, an explanation will be required. Failure to provide a satisfactory explanation may lead to exclusion. |     **Responses marked with an asterisk (\*) may lead to your application being rejected, therefore please ensure that you provide further details where requested.** | | |
| **4.1** | Does your organisation / Practice have a Safeguarding Adults At Risk policy in place? | Yes / No\* |
| If **‘No’**, please explain why: | |
| **4.2** | Does your organisation / Practice have a Safeguarding Children At Risk policy in place? | Yes / No\* |
| If **‘No’**, please explain why: | |
| **4.3** | Are all relevant staff appropriately checked by the Disclosure and Barring Service? | Yes / No\* |
| If **‘No’**, please explain why: | |
| **4.4** | **GDPR**  Please confirm that you have in place, or that you will have in place by contract award, the human and technical resources to perform the contract to ensure compliance with the General Data Protection Regulation and to ensure the protection of the rights of data subjects.  Yes ☐  No ☐  If No please provide an explanation | |

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| **5** | **Clinical Governance** | | | |
| | **Scoring** | **Requirements** | | --- | --- | | Required Data | **5.1** The data is required for management purposes only and will not be scored / assessed. If the information requested is not provided your tender, however, will be judged non-compliant unless there is an acceptable reason for its omission. | | Pass/Fail | **5.2** Providers must confirm that they have in place appropriate clinical governance policies. |     **Responses marked with an asterisk (\*) may lead to your application being rejected, therefore please ensure that you provide further details where requested.** | | | | |
| **5.1** | Enter the details of your clinical governance lead (CGL) | Name: |  | |
| Job Title: |  | |
| E-mail: |  | |
| **5.2** | Please confirm that you have in place, appropriate clinical governance policies in place. | | | Yes / No\* |
| If **‘No’**, please explain why: | | | |

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| **6** | **Equality and Diversity** | |
| | **Scoring** | **Requirements** | | --- | --- | | Pass/Fail | Confirmation required as to whether policies are in place and whether any findings of unlawful discrimination have been made. Explanations are required where policies are not in place and where your organisation has been found to be in breach of Equality Law. Failure to provide a satisfactory explanation may lead to exclusion. |     **Responses marked with an asterisk (\*) may lead to your application being rejected, therefore please ensure that you provide further details where requested.** | | |
| **6.1** | Does your organisation have an Equality and Diversity policy in place? | Yes / No\* |
| If **‘No’**, please explain why: | |
| **6.2** | In the last 3 years, has any finding of unlawful discrimination or other breach of Equality Law been made against your organisation by any court or employment tribunal or Employment Appeal Tribunal? | Yes\* / No |
| If **‘Yes’**, please provide details, including any steps taken as a consequence of the findings: | |

| **7.** | **Health and Safety** | |
| --- | --- | --- |
| | **Scoring** | **Requirements** | | --- | --- | | Pass/Fail | The Council is entitled to eliminate your application from the accreditation process if there are concerns over your Health & Safety procedures and processes. However, if you are able to give a satisfactory explanation your application may be allowed to proceed. |   Please be aware that **this section contains questions that may lead to your application being rejected**. Responses marked with an asterisk (\*) are likely to result in elimination unless you are able to give a satisfactory explanation  If you have been prosecuted or had any notices served in relation to Health and Safety, you must give full details on the incident/s including any remedial action taken. Please also state whether your Organisation has a written Health & Safety policy. | | |
| **7.1** | Does your organisation (and any sub-contractors) comply with the Health and Safety at Work etc Act 1974 and all associated legislation? This includes, but is not limited to, the premises and any associated equipment where the services are carried out. | Yes / No\* |
| If **No** – please explain why | |
| **7.2** | Please self-certify that your organisation (and any sub-contractors) has a Health and Safety Policy and Arrangements that comply with current legislative requirements | Yes / No\* |
| If **No** – please explain why | |
| **7.3** | In the last 3 years, has your organisation or any of its Directors or Executive Officers (or any sub-contractors) been subject to enforcement action by the Health & Safety Executive, Local Authority or Fire Authority? If yes, please provide details including any actions taken as a result. | Yes\* / No |
|  | If **Yes** – please give details of the incident/s – including date(s) – and any remedial action taken | |

| **PART B – RESPONSE TO SERVICES TO BE DELIVERED** |
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Please indicate in the table below the Lot(s) you wish to deliver. Applicants may apply to deliver one, some or all of the Lots available.

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| **Lot** | **Description** | **Please specify the Lot(s) you wish to deliver** | **Instruction** |
| Lot 1 | Fitting and removal of Intrauterine Contraceptive Device (IUCD) for contraceptive purposes for both registered and non-registered patients with GP Practices (see Appendix 1 Service Specification) | Yes / No | Complete section 8 |
| Lot 2 | Fitting and removal of Sub-Dermal Implants (SDI) for contraceptive purposes for both registered and non-registered patients with GP Practices (see Appendix 2 Service Specification). | Yes / No | Complete section 9 |
| Lot 3 | Asymptomatic Sexual Health screening for both registered and non-registered patients (aged 15-24 years) with GP practices (see Appendix 3 Service Specification). | Yes / No | Complete section 10 |
| Lot 4 | Asymptomatic Chlamydia screening and treatment for both registered and non-registered female patients (aged 15-24 years) with GP practices (see Appendix 4 Service Specification). | Yes / No | Complete section 11 |

Applicants are required to submit responses to the questions below for the Lot(s) that you are applying to deliver. The evaluation of the responses to these questions is detailed in the Evaluation Approach.

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| **8** | **Lot 1 - Fitting and Removal of Intrauterine Contraceptive Device (IUCD) for Contraceptive purposes** | |
| | **Scoring** | **Requirements** | | --- | --- | | Pass/Fail | Applicants must confirm that the named professionals possess the necessary documentation / certifications required to deliver the service.. Failure to satisfy these requirements may lead to exclusion. | | | |
| **8.1** Please complete the following table in respect of the General Practitioners / Registered Nurses that will be delivering this service:   |  |  |  |  |  | | --- | --- | --- | --- | --- | | **GENERAL PRACTIONERS** | | | | | | **Name** | **FSRH\* Letter of Competency in Intrauterine Techniques (LoC IUT) (Date)** | **Date of Letter** | **Date Recertification / LoC Due** | **Recertification Date** | |  | Yes / No |  |  |  | |  | Yes / No |  |  |  | |  | Yes / No |  |  |  | |  | Yes / No |  |  |  | |  | Yes / No |  |  |  | |  | Yes / No |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | | **REGISTERED NURSES** | | | | | | **Name** | **FSRH\* Letter of Competency in Intrauterine Techniques (Loc IUT) or RCN Letter of Accreditation in Intrauterine Techniques (in date)** | **Date of Letter** | **If no LoC /or RCN Letter of Accreditation, Please list other recognised sexual health qualification\*\*** | **Recertification Date** | |  | Yes / No |  |  |  | |  | Yes / No |  |  |  | |  | Yes / No |  |  |  | |  | Yes / No |  |  |  | |  | Yes / No |  |  |  | |  | Yes / No |  |  |  |   ***\*FSRH (Faculty of Sexual and Reproductive Healthcare)*** | | |
| **8.2** | Please confirm that you have read and understood the patient eligibility criteria as set out in Appendix 1 Service Specification. | Yes / No |

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| **9** | **Lot 2 - Fitting and Removal of Sub-Dermal Implants (SDI) for Contraceptive purposes** | |
| | **Scoring** | **Requirements** | | --- | --- | | Pass/Fail | Applicants must confirm that the named professionals possess the necessary documentation / certifications required to deliver the service. / certification. Failure to satisfy these requirements may lead to exclusion. | | | |
| **9.1** Please complete the following table in respect of the General Practitioners / Registered Nurses that will be delivering this service:   |  |  |  |  |  | | --- | --- | --- | --- | --- | | **GENERAL PRACTIONERS** | | | | | | **Name** | **FSRH\* Letter of Competency for Sub-Dermal Contraceptive Techniques (LoC, SDI)** | **Date of Letter** | **LoC Due** | **Recertification Date** | |  | Yes / No |  |  |  | |  | Yes / No |  |  |  | |  | Yes / No |  |  |  | |  | Yes / No |  |  |  | |  | Yes / No |  |  |  | |  | Yes / No |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | --- | | **REGISTERED NURSES** | | | | | | **Name** | **FSRH\* Letter of Competency for Sub-Dermal Contraceptive Techniques (LoC, SDI) or RCN Letter of Accreditation for Sub-Dermal Techniques** | **Date of Letter** | **If no LoC / RCN of Accreditation,**  **Please list other recognised sexual health qualification\*\*** | **Recertification Date** | |  | Yes / No |  |  |  | |  | Yes / No |  |  |  | |  | Yes / No |  |  |  | |  | Yes / No |  |  |  | |  | Yes / No |  |  |  | |  | Yes / No |  |  |  |     ***\*FSRH (Faculty of Sexual and Reproductive Healthcare)*** | | |
| **9.2** | Please confirm that you have read and understood the patient eligibility criteria as set out in Appendix 2 Service Specification. | Yes / No |

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| **10** | **Lot 3 - Asymptomatic Sexual Health Screening and Treatment (GP)** | |
| | **Scoring** | **Requirements** | | --- | --- | | Pass/Fail | Applicants must confirm that the named professionals possess the necessary documentation / certifications required to deliver the service.. Failure to satisfy these requirements may lead to exclusion. | | | |
| **10.1** Please complete the following table in respect of the General Practitioners / Registered Nurses / Health Care Assistants that will be delivering this service:   |  |  |  |  | | --- | --- | --- | --- | | **GENERAL PRACTIONERS** | | | | | **Name** | **Evidence of BASHH STIF\* Training Course (incl. Data and Level) Completion** | **If no BASHH STIF Training Course - do you have Evidence of 5 CPD Points in Areas Pertaining to Sexual Health?\*\*** | **Recertification dates if applicable** | |  | Yes / No | Yes / No |  | |  | Yes / No | Yes / No |  | |  | Yes / No | Yes / No |  | |  | Yes / No | Yes / No |  | |  | Yes / No | Yes / No |  |  |  |  |  |  | | --- | --- | --- | --- | | **REGISTERED NURSES** | | | | | **Name** | **Evidence of BASHH STIF\* Training Course (incl. Data and Level) Completion** | **If no BASHH STIF Training Course - do you have Evidence of 5 CPD Points in Areas Pertaining to Sexual Health?\*\*** | **Recertification dates if applicable** | |  | Yes / No | Yes / No |  | |  | Yes / No | Yes / No |  | |  | Yes / No | Yes / No |  | |  | Yes / No | Yes / No |  | |  | Yes / No | Yes / No |  |  |  |  |  |  | | --- | --- | --- | --- | | **HEALTHCARE ASSISTANTS** | | | | | **Name** | **Evidence of BASHH STIF\* Training Course (incl. Data and Level) Completion** | **If no BASHH STIF Training Course - do you have Evidence of 5 CPD Points in Areas Pertaining to Sexual Health?\*\*** | **Recertification dates if applicable** | |  | Yes / No | Yes / No |  | |  | Yes / No | Yes / No |  | |  | Yes / No | Yes / No |  | |  | Yes / No | Yes / No |  | |  | Yes / No | Yes / No |  |   ***\*BASHH (British Association for Sexual Health & HIV) STIF (Sexually Transmitted Infection Foundation)*** | | |
| **10.2** | Please confirm that you have read and understood the patient eligibility criteria as set out in Appendix 3 Service Specification. | Yes / No |

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| **11** | **Lot 4 - Asymptomatic Chlamydia Screening and Treatment (GP)** | |
| | **Scoring** | **Requirements** | | --- | --- | | Required Data | The data provided is for information only and will not be scored / assessed but if the information requested is not provided the bid will be judged non-compliant unless there is an acceptable reason for its omission. | | | |
| **11.1** Please complete the following table in respect of the General Practitioners / Registered Nurses / Health Care Assistants that will be delivering this service:   |  |  |  |  | | --- | --- | --- | --- | | **GENERAL PRACTITIONERS** | | | | | **Name** | **Please state any Chlamydia Screening Training undertaken\* (if no training has been undertaken, please state ‘nil’)** | **Date undertaken** | **Recertification dates if applicable** | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  |      |  |  |  |  | | --- | --- | --- | --- | | **REGISTERED NURSES** | | | | | **Name** | **Please state any Chlamydia Screening Training undertaken\* (if no training has been undertaken, please state ‘nil’)** | **Date undertaken** | **Recertification dates if applicable** | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  |  |  |  |  |  | | --- | --- | --- | --- | | **HEALTHCARE ASSISTANTS** | | | | | **Name** | **Please state any Chlamydia Screening Training undertaken\* (if no training has been undertaken, please state ‘nil’)** | **Date undertaken** | **Recertification dates if applicable** | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | |  |  |  |  | | | |
| **11.2** | Please confirm that you have read and understood the patient eligibility criteria as set out in Appendix 4 Service Specification. | Yes / No |

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| **12** | **Registration and Training – Evidence to Practice** |
| Please complete the following table: providing details of all General Practitioners, Registered Nurses and Health Care Assistants (named in sections 8 – 11 above) that will be delivering the services you wish to be accredited for.   |  |  |  | | --- | --- | --- | | **GENERAL PRACTIONERS** | | | | **Name** | **Date of GMC Registration** | **Date DBS undertaken** | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  |  |  |  |  | | --- | --- | --- | | **REGISTERED NURSES** | | | | **Name** | **Date of NMC Registration** | **Date DBS undertaken** | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  | |  |  |  |  |  |  | | --- | --- | | **HEALTH CARE ASSISTANTS** | | | **Name** | **Date DBS undertaken** | |  |  | |  |  | |  |  | |  |  | |  |  | |  |  | |  |  |   **Please note**: Only those individuals named above will be able to deliver these services as outlined in the Service Specifications for each Lot. Should any other staff achieve the required competencies or any new staff join your Practice, you must first submit evidence of their competency to undertake the LCPHS before they commence any activity. | |

| **TERMS AND CONDITIONS** |
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| **Agreement**  The following documents shall form part of the Contract between the Council and the successful Applicants which shall be legally binding on both parties:   * Contract Terms and Conditions * Service Specification (including appendices) * Accreditation Questionnaire / Application Form   **Agreement to Terms and Conditions**  By submitting an application form, Applicants are agreeing to be bound by the terms of this Accreditation and the Contract without further negotiation or amendment, and must sign the Declaration accordingly.  Whilst the Council is prepared to give consideration to any changes of a minor nature, it is not prepared to accept material changes to the terms and conditions. For the avoidance of doubt therefore, if Applicants submit an application form which is subject to a qualification which the Council deems ‘material’ and unacceptable, the Applicant will be invited to withdraw the qualification and the application form will be evaluated without it. Should the Applicant not agree to withdraw the qualification, the Applicant will be disqualified and deemed to be non-compliant. The Application shall not be considered further. |

| **DECLARATION** |
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| I/We declare that to the best of my knowledge the answers submitted in this Application (and any supporting information) is correct. I/We understand that the information will be used in the evaluation process to assess my organisation’s suitability to provide these services for Nottingham City Council  I/We the undersigned do hereby offer and undertake on the acceptance of this Application (either wholly or in part) by the Council, to provide the service(s) described in the Contract in accordance with all documents that constitute the Contract.  Unless and until a separate formal agreement is prepared and executed this Application, if accepted, together with the said General Terms and Conditions, [Special Conditions of Contract], Specification and Pricing Schedule, together with your written acceptance thereof shall constitute a binding contract between us. | | | |
| **FORM COMPLETED BY** | | | |
| Name. |  | Position (Job Title) |  |
| Date. |  | Telephone Number |  |
| Signature. |  | | |
| **WITNESSED BY** | | | |
| Name. |  | Position (Job Title). |  |
| Date. |  | Telephone Number. |  |
| Signature. |  | | |