FORM #1: Title Page RFI # 763 for WDBCCC Healthcare Initiative Management

|  |  |  |  |
| --- | --- | --- | --- |
| **A. Name of Organization** |  | | |
| **B. Address of Organization & Organization website** |  | | |
| **C. Name/Title of Contact Person(s)** |  | | |
| **D. Phone/Fax/E-mail of Contacts** |  | | |
| E. Federal Tax I.D. Number |  | | |
| **F. Are you MBE/WBE certified?** | Yes No Certifying Agency: | | |
|  |  | **Total Funds Requested:** | **$** |
| **J. Is your organization incorporated as a:**  \_\_\_\_\_ for-profit \_\_\_\_\_ non-profit \_\_\_\_\_ public agency | | | |
| Brief history and the mission/vision of your organization: | | | |

The authorized representative of the above organization certifies to the best of his/her knowledge and belief, the information supplied in the Statement of Interest is true and accurate.

Signature of Authorized Representative Date

Typed Name and Title Telephone and Extension