



PROFILE OF FIRM FORM

(1) Prime ____ Sub-contractor ____ (This form must be completed by and for each).

(2) Name of Firm: _____ Telephone: _____ Fax: _____

(3) Street Address, City, State, Zip: _____

(4) Please attached a brief biography/resume of the company, including the following information:
 (a) Year Firm Established; (b) Year Firm Established in [JURISDICTION]; (c) Former Name and Year Established (if applicable); (d) Name of Parent Company and Date Acquired (if applicable).

(5) Identify Principals/Partners in Firm (submit under Tab No. 5 a brief professional resume for each):

NAME	TITLE	% OF OWNERSHIP

(6) Identify the individual(s) that will act as project manager and any other supervisory personnel that will work on project; please submit under Tab No. 5 a brief resume for each. (Do not duplicate any resumes required above):

NAME	TITLE

(7) Proposer Diversity Statement: Circle all of the following that apply to the ownership of this firm and enter where provided the correct percentage (%) of ownership of each:

- Caucasian American (Male) _____%
 Public-Held Corp _____%
 Government Agency _____%
 Non-Profit Org. _____%

Resident- (RBE), Minority- (MBE), or Woman-Owned (WBE) Business Enterprise (Qualifies by virtue of 51% or more ownership and active management by one or more of the following:

- Resident-Owned* _____%
 African American _____%
 **Native American _____%
 Hispanic American _____%
 Asian/Pacific American _____%
 Hasidic Jew _____%
 Asian/Indian American _____%

- Woman-Owned (MBE) _____%
 Woman-Owned (Caucasian) _____%
 Disabled Veteran _____%
 Other (Specify): _____%

MBE/WBE Certification Number: _____ - _____

Certified by (Agency): _____

(NOTE: A CERTIFICATION/NUMBER NOT REQUIRED TO PROPOSE - ENTER IF AVAILABLE)



ROFILE OF FIRM FORM

- (8) Federal Tax ID No.: _____
- (9) [APPROPRIATE JURISDICTION] Business License No.: _____
- (10) State of _____ License Type and No.: _____
- (11) Worker's Compensation Insurance Carrier: _____
Policy No.: _____ Expiration Date: _____
- (12) General Liability Insurance Carrier: _____
Policy No. _____ Expiration Date: _____
- (13) Professional Liability Insurance Carrier: _____
Policy No. _____ Expiration Date: _____
- (14) Debarred Statement: Has this firm, or any principal(s) ever been debarred from providing any services by the Federal Government, any state government, or any local government agency _____?
Yes No
If "Yes," please attach a full detailed explanation, including dates, circumstances and current status.
- (15) Disclosure Statement: Does this firm or any principals thereof have any current, past personal or professional relationship with any Commissioner or Officer of the HA? Yes No
If "Yes," please attach a full detailed explanation, including dates, circumstances and current status.
- (16) Verification Statement: The undersigned proposer hereby states that by completing and submitting this form he/she is verifying that all information provided herein is, to the best of his/her knowledge, true and accurate, and agrees that if the HA discovers that any information entered herein is false, that shall entitle the HA to not consider nor make award or to cancel any award with the undersigned party.

Signature

Company

Printed Name

Date