MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION
REQUEST FOR PROPOSAL

FOR PHARMACY SERVICES

VENDOR REFERENCES

1) Agency Name_____

Agency Address _____

Contact Person _____Contact Number _____

E-Mail _____ Fax Number _____

Number of Sites _____ Number of Patients _____

Please list facility type:

Please list Accreditations:

Contract Term (original, extensions, renewals, rebids) _____

_____Current Contract _____Prior Contract

Contract End ____Terminated, if so specify by whom ____agency ____vendor

Reason _____

____Lost in Rebid, if so specify award recipient _____

Reason _____

____Other, specify (i.e. returned to self-operated, transition to University)

Reason _____

2) Agency Name_____

Agency Address _____

Contact Person _____Contact Number _____

E-Mail _____ Fax Number _____

Number of Sites _____ Number of ~~Inmates~~ patients/residents _____

VENDOR REFERENCES
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Facility Type:

Accreditation:

Contract Term (original, extensions, renewals, rebids) _____

_____Current Contract _____Prior Contract

Contract End ____Terminated, if so specify by whom ____agency ____vendor

Reason _____

____Lost in Rebid, if so specify award recipient _____

Reason _____

____Other, specify (i.e. returned to self-operated, transition to University)

Reason _____

3) Agency Name_____

Agency Address _____

Contact Person _____Contact Number _____

E-Mail _____ Fax Number _____

Number of Sites _____ Number of ~~Inmates~~ patients/residents _____

Facility Type:

Accreditation:

Contract Term (original, extensions, renewals, rebids) _____

_____Current Contract _____Prior Contract

Contract End ____Terminated, if so specify by whom ____agency ____vendor

Reason _____

____Lost in Rebid, if so specify award recipient _____

VENDOR REFERENCES
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Reason _____

____Other, specify (i.e. returned to self-operated, transition to University)

Reason _____

4) Agency Name_____

Agency Address _____

Contact Person _____Contact Number _____

E-Mail _____ Fax Number _____

Number of Sites _____ Number of ~~Inmates~~ patients/residents _____

Facility Type:

Accreditation:

Contract Term (original, extensions, renewals, rebids) _____

_____Current Contract _____Prior Contract

Contract End ____Terminated, if so specify by whom ____agency ____vendor

Reason _____

____Lost in Rebid, if so specify award recipient _____

Reason _____

____Other, specify (i.e. returned to self-operated, transition to University)

Reason _____

5) Agency Name_____

Agency Address _____

Contact Person _____Contact Number _____

VENDOR REFERENCES
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E-Mail _____ Fax Number _____

Number of Sites _____ Number of ~~Inmates~~ patients/residents _____

Facility Type:

Accreditation:

Contract Term (original, extensions, renewals, rebids) _____

_____Current Contract _____Prior Contract

Contract End ____Terminated, if so specify by whom ____agency ____vendor

Reason _____

____Lost in Rebid, if so specify award recipient _____

Reason _____

____Other, specify (i.e. returned to self-operated, transition to University)

Reason _____

Printed Name _____

Authorized Signator _____

Title _____

Date _____

Addition ~~Deletion~~