PROFILE OF FIRM FORM
(RFP Attachment C)

(This Form must be fully completed and placed under Tab No. 3 of the "hard copy" tabbed proposal submittal.)

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

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

(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 Rhode Island; (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):

[Table No. 1]

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):

[Table No. 2]

Name	Title

_____ _____ _____ _____

Signature **Date** **Printed Name** **Company**

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

☐ Caucasian American (Male)	☐ Public-Held Corporation	☐ Government Agency	☐ Non-Profit Organization
_____%	_____%	_____%	_____%

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):
_____%	_____%	_____%	_____%

WMBE Certification Number:
Certified by (What Agency):
(NOTE: A CERTIFICATION/NUMBER IS NOT REQUIRED TO PROPOSE – ENTER IF AVAILABLE)

(8) Federal Tax ID No.:

(9) Local Business License No. (if applicable):

(10) State of Rhode Island License Type and No.:

(11) Federal License Type and No.:

(12) Worker's Compensation Insurance Carrier:
Policy No.:
Expiration Date:

(13) General Liability Insurance Carrier:
Policy No.
Expiration Date:

(14) Professional Liability Insurance Carrier:
Policy No.

_____	_____	_____	_____
Signature	**Date**	**Printed Name**	**Company**

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Expiration Date:

_____	_____	_____	_____
Signature	**Date**	**Printed Name**	**Company**