PUBLIC RELATIONS PROPOSAL FORM

STATE OF OREGON MEDICAL BOARD – 1500 SW FIRST AVENUE – SUITE 620 - PORTLAND, OR 97201 – (971) 673-2700
All pricing will be good for sixty (60) days after procurement closes.

Proposer: ____

FEIN ID# or SSN: ____

OR Business ID: ____

Tax Filing Address: ______________________________________

Mailing Address: ____ **(If different)**

Phone: ____

Fax: ____

Email: ____

Do you have at least 5 years' related experience? ☐ No ☐ Yes
Do you have experience working with Government Agencies? ☐ No ☐ Yes

Professional references (please provide exactly 3):

1- **Name:** ______________________________
Company: ___________________________
Phone: ______________________________
Email: _______________________________

2- **Name:** ______________________________
Company: ___________________________
Phone: ______________________________
Email: _______________________________

3- **Name:** ______________________________
Company: ___________________________
Phone: ______________________________
Email: _______________________________

AGREEMENT/CERTIFICATION. The undersigned agrees and certifies that they have read and understand all proposal instructions, specifications, enclosed terms and conditions, and is the authorized representative of the bidder. The undersigned attests that the persons who will perform the services, if this proposal is accepted, **is qualified for the Work described in the Statement of Work and meets all specified requirements** and can provide proof of any certification or degree listed. The undersigned agrees that all work products are the exclusive property of the Oregon Medical Board and shall not be distributed to any other party without prior written authority.

Authorized Signature: _________________________________ **Date:** ____________________

Please Print Name: ___________________________________