Attachment I
Client History Form
Pharmacy Services
710-24-062

Attachment I

Pharmacy Services Client History Form

Instructions: This form is intended to help the State gain a more complete understanding of each Respondent's experience. This form **must** be complete and accurate.

The State reserves the right to verify the accuracy of these answers by contacting any of the listed clients, and all applicable clients **must** be listed. Omission of a client will constitute a failure to complete this form.

For purposes of this form, the "client" is not an individual but the entity which held the contract. By way of explanation, in the Contract resulting from this IFB, Arkansas DHS will be the client. For each listed client, Respondents may (but are not required) provide the contact information for a person at the client entity who is knowledgeable of the named project. If the State contacts clients listed on this form, the State reserves the right to contact the listed individual or another person at the listed client.

The boxes below each prompt will expand if necessary. The form **must** be signed (please see the final page) by the same signatory who signed the *Response Signature Page*.

1. Please list at least three (3) clients where you (the prime contractor only) **served as the prime contractor** for dispensing pharmaceuticals in similar surroundings (Nursing Homes, Residential Care, etc.) in the past five (5) years. Please include the following: name(s) of facility, address of facility, brief overview of the facility including current census, duration of services provided, and client contact information. If there are no contracts which meet this definition, please state "none."

Authorized Signature: ____ **Title:** ______________________________

Printed/Typed Name: ____ **Date:** ______________________________