

## CLIENT HISTORY FORM

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

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 form **must** be signed (please see the final page) by the same signatory who signed the Bid Signature Page.

1. Please describe your experience where you served as the prime contractor (the prime contractor only) treating and interacting with patients with developmental disabilities. Please provide a description of the services, years of experience, population served, and location. If there are no contracts which meet this definition, please state "none."

2. Please list at least two (2) clients where you (the prime contractor only) served as the prime Contractor providing dental services. Please provide years of experience, population(s)

served, location, and client contact information. If there are no contracts which meet this definition, please state "none."

**Authorized Signature:** \_\_\_\_\_ **Title:** \_\_\_\_\_  
*Use Ink Only.*

**Printed/Typed Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_