MACOMB COUNTY COMMUNITY MENTAL HEALTH
PROCUREMENT OF SERVICES

NETWORK PROVIDER QUALIFICATION STATEMENT

License No.: _____ Years in Business: _____

Former Business Names Operated Under:_____
_____

If Corporation: Corporate ID No. _____ Date Incorporated: _____

Names of President, Vice-President, Secretary and Treasurer:
_____
_____
_____

Names of All Partners: _____
_____
_____

Limited or General : _____

If D.B.A., List Name of Primary License: _____

List of Major Services Your Company Has Provided – Location and References With Telephone Number:
_____
_____
_____

List Training, Education, etc. of Key Individuals in Organization: _____
_____
_____
_____

List Trade References: _____
_____

List Bank References: _____
_____

Attach copy of personal or business financial statement (include name, telephone number, address of accountant, bookkeeper, etc.)

Name, Address and Telephone Number of Bonding Company / Agent:
_____
_____
_____

_____ _____
Signature Date Notary Public / Personal Signature Guarantee