Attachment F
Client History Form
Physician Services
710-25-045

Attachment F
Physician Services

Instructions: This form is intended to help the State gain a more complete understanding of each Respondent's 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 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 clients where you (the prime contractor only) served as the prime contractor for physician services treating developmentally disabled individuals for at least five (5) years. For each client, please specify the organization/agency/division (not individuals). Please briefly describe the scope of the contract, duration of services including dates, and population served. If there are no contracts which meet this definition, please state "none."

Authorized Signature: _____ **Title:** _____

Printed/Typed Name: _____ **Date:** _____