

***BID RESPONSE PACKET***  
***710-21-0007***

## BID SIGNATURE PAGE

Type or Print the following information.


PROSPECTIVE CONTRACTOR'S INFORMATION					
Company:	Kenneth E. Rains LLC				
Address:	2100 Hogan Lane				
City:	Conway	State:	AR	Zip Code:	72034
Business Designation:	<input checked="" type="checkbox"/> Individual <input checked="" type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Public Service Corp <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> Nonprofit				
Minority and Women-Owned Designation*:	<input checked="" type="checkbox"/> Not Applicable <input type="checkbox"/> American Indian <input type="checkbox"/> Asian American <input type="checkbox"/> Service Disabled Veteran <input type="checkbox"/> African American <input type="checkbox"/> Hispanic American <input type="checkbox"/> Pacific Islander American <input type="checkbox"/> Women-Owned				
AR Certification #:		_____ * See Minority and Women-Owned Business Policy			

PROSPECTIVE CONTRACTOR CONTACT INFORMATION			
Provide contact information to be used for bid solicitation related matters.			
Contact Person:	Kenneth E. Rains	Title:	Owner/Sole Proprietor
Phone:	501-472-8382	Alternate Phone:	Kenneth E. Rains LLC
Email:	krains@conwaycorp.net		

CONFIRMATION OF REDACTED COPY
<input type="checkbox"/> YES, a redacted copy of submission documents is enclosed. <input checked="" type="checkbox"/> NO, a redacted copy of submission documents is <u>not</u> enclosed. I understand a full copy of non-redacted submission documents will be released if requested.  <i>Note: If a redacted copy of the submission documents is not provided with Prospective Contractor's response packet, and neither box is checked, a copy of the non-redacted documents, with the exception of financial data (other than pricing), will be released in response to any request made under the Arkansas Freedom of Information Act (FOIA). See Bid Solicitation for additional information.</i>
ILLEGAL IMMIGRANT CONFIRMATION
By signing and submitting a response to this <i>Bid Solicitation</i> , a Prospective Contractor agrees and certifies that they do not employ or contract with illegal immigrants. If selected, the Prospective Contractor certifies that they will not employ or contract with illegal immigrants during the aggregate term of a contract.
ISRAEL BOYCOTT RESTRICTION CONFIRMATION
By checking the box below, a Prospective Contractor agrees and certifies that they do not boycott Israel, and if selected, will not boycott Israel during the aggregate term of the contract.  <input checked="" type="checkbox"/> Prospective Contractor does not and will not boycott Israel.

**An official authorized to bind the Prospective Contractor to a resultant contract must sign below.**

The signature below signifies agreement that any exception that conflicts with a Requirement of this *Bid Solicitation* will cause the Prospective Contractor's bid to be disqualified:


Authorized Signature:  Title: Owner/Sole Proprietor  
Use Ink Only.

Printed/Typed Name: Kenneth E. Rains Date: 02/05/21

## **SECTION 1 - VENDOR AGREEMENT AND COMPLIANCE**

- Any requested exceptions to items in this section which are NON-mandatory must be declared below or as an attachment to this page. Vendor must clearly explain the requested exception and should label the request to reference the specific solicitation item number to which the exception applies.
- Exceptions to Requirements shall cause the vendor's proposal to be disqualified.

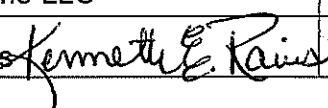
By signature below, vendor agrees to and **shall** fully comply with all Requirements as shown in this section of the bid solicitation.

<b>Vendor Name:</b>	Kenneth E. Rains LLC	<b>Date:</b>	02/05/21
<b>Signature:</b>	Kenneth E. Rains 	<b>Title:</b>	Owner/Sole Proprietor
<b>Printed Name:</b>	Kenneth E. Rains		

## **SECTION 2 - VENDOR AGREEMENT AND COMPLIANCE**

- Any requested exceptions to items in this section which are NON-mandatory must be declared below or as an attachment to this page. Vendor **must** clearly explain the requested exception, and should label the request to reference the specific solicitation item number to which the exception applies.
- Exceptions to Requirements **shall** cause the vendor's proposal to be disqualified.


By signature below, vendor agrees to and shall fully comply with all Requirements as shown in this section of the bid solicitation.

<b>Vendor Name:</b>	Kenneth E. Rains LLC	<b>Date:</b>	02/05/21
<b>Signature:</b>	Kenneth E. Rains 	<b>Title:</b>	Owner/Sole Proprietor
<b>Printed Name:</b>	Kenneth E. Rains		

### **SECTION 3 - VENDOR AGREEMENT AND COMPLIANCE**

- *Exceptions to Requirements shall cause the vendor's proposal to be disqualified.*


By signature below, vendor agrees to and shall fully comply with all Requirements as shown in this section of the bid solicitation.

<b>Vendor Name:</b>	Kenneth E. Rains LLC	<b>Date:</b>	02/05/21
<b>Signature:</b>	Kenneth E. Rains 	<b>Title:</b>	Owner/Sole Proprietor
<b>Printed Name:</b>	Kenneth E. Rains		

## **SECTION 4 - VENDOR AGREEMENT AND COMPLIANCE**

- *Exceptions to Requirements shall cause the vendor's proposal to be disqualified.*

By signature below, vendor agrees to and **shall** fully comply with all Requirements as shown in this section of the bid solicitation.

<b>Vendor Name:</b>	Kenneth E. Rains LLC	<b>Date:</b>	02/05/21
<b>Signature:</b>	Kenneth E. Rains 	<b>Title:</b>	Owner/Sole Proprietor
<b>Printed Name:</b>	Kenneth E. Rains		

## **PROPOSED SUBCONTRACTORS FORM**

- Do not include additional information relating to subcontractors on this form or as an attachment to this form.

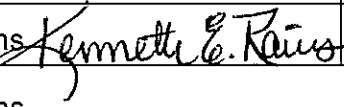
**PROSPECTIVE CONTRACTOR PROPOSES TO USE THE FOLLOWING SUBCONTRACTOR(S) TO PROVIDE SERVICES.**

*Type or Print the following information*

Subcontractor's Company Name	Street Address	City, State, ZIP

☒ **PROSPECTIVE CONTRACTOR DOES NOT PROPOSE TO USE SUBCONTRACTORS TO PERFORM SERVICES.**

By signature below, vendor agrees to and shall fully comply with all Requirements related to subcontractors as shown in the bid solicitation.

<b>Vendor Name:</b>	Kenneth E. Rains LLC	<b>Date:</b>	02/05/21
<b>Signature:</b>	Kenneth E. Rains 	<b>Title:</b>	Owner/Sole Proprietor
<b>Printed Name:</b>	Kenneth E. Rains		

**Illegal Immigrant Form**

**From** Illegal Immigrant Form <AASIS-OSP@dfa.arkansas.gov>  
**To** <krains@conwaycorp.net>  
**Reply-To** AASIS-OSP@dfa.arkansas.gov <AASIS-OSP@dfa.arkansas.gov>  
**Date** 2021-01-29 11:03  
**Priority** Normal

**TSS Illegal Immigrant Contractor Disclosure Certification****Illegal Immigrant Form**

**Vendor:** Kenneth E. Rains

**Tax ID:** 4248

**Disclosure Statement:** I certify that I **DO NOT** employ or contract with an illegal immigrant.

**Contact E-mail:** krains@conwaycorp.net

**Submitted on:** 01-29-21

**Valid through:** 01-28-22



[Home](#)[Welcome Agency - Login](#)

### Submission Confirmation

Thank you for your submission. This submission is valid for one year.

We have recorded your submission. Please [click here](#) to return to the home page.

Print Disclosure Submission

Disclosure forms are valid for one year.

**Vendor:** Kenneth E. Rains

**Tax ID:** 4248

**Disclosure Statement:** I certify that I **DO NOT** employ or contract with an illegal immigrant.

**Contact E-mail:** [krains@conwaycorp.net](mailto:krains@conwaycorp.net)

**Submitted on:** 01-29-21

**Valid through:** 01-28-22

Kenneth E. Rains LLC

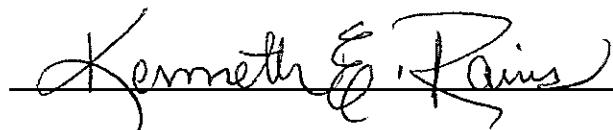
Registered Respiratory Therapist Consultant

2100 Hogan Lane, Conway, Arkansas 72034

Addendum to: Limited Liability Company

Statement concerning EEO Policy:

As the Sole-Proprietor of the Limited Liability Company, I do not have a EEO Policy.

 Signature  
Kenneth E. Rains

# KENNETH E. RAINS

2100 HOGAN LANE, CONWAY, ARKANSAS 72034

KRAINS@CONWAYCORP.NET---501-472-8382

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## EXPERIENCE

AUGUST 1980—AUGUST 2014

### **DIRECTOR RESPIRATORY THERAPY, CONWAY REGIONAL MEDICAL CENTER**

Managed all aspects of the Respiratory Therapy Department including Cardio-pulmonary care, Pulmonary Function testing, EKG testing, ICU-CVICU mechanical ventilation care and Nursery with 32 Respiratory Therapists on staff. Determined the budget, staffing and Supervision.

AUGUST 1990---AUGUST 2014 AS PART-TIME .... AUGUST 2014---PRESENT AS FULL TIME

### **CONTRACT RESPIRATORY THERAPIST, CONWAY HUMAN DEVELOPMENT CENTER**

Hired as the only Respiratory Therapist to work alongside the Physicians, Nurses and Direct Care staff to provide Respiratory Care education and oversight; maintain Oxygen Therapy and CPAP Therapy equipment and supplies; provide direct care along with the Nurses to Residents at CHDC as ordered by the Physicians. Perform EKGs and Overnight Pulse Oximetry Studies for the Heart Clinic and Sleep Clinic on the CHDC campus. I also assist with COVID-19 fit testing of N-95 masks and weekly COVID-19 Rapid testing as needed. I also participate in Infection Prevention and Dysphasia Committee meetings.

MAY 2001---MAY 2013 AS PART-TIME

### **RESPIRATORY THERAPY Consultant, APEX MEDICAL RENTAL**

Provided Respiratory Therapy services for Home Care Oxygen Therapy Patients.

## EDUCATION

MAY 1973

### **GRADUATE OF HIGH SCHOOL DEGREE, LESLIE, ARKANSAS**

AUGUST 1978

### **BACHELOR OF SCIENCE DEGREE, UNIVERSITY OF CENTRAL ARKANSAS, CONWAY, ARKANSAS**

### **RESPIRATORY THERAPY PROGRAM, SCHOOL OF HEALTH SCIENCES, BAPTIST MEDICAL CENTER, LITTLE ROCK, ARKANSAS**

## CREDENTIALS

DECEMBER 1979

### **REGISTERED RESPIRATORY THERAPIST # 9259, THE NATIONAL BOARD FOR RESPIRATORY THERAPY, OLATHE, KANSAS**

**JUNE 1996---PRESENT (RENEWED ANNUALLY)**

**RESPIRATORY CARE LICENSE # RCP-1203, ARKANSAS STATE MEDICAL BOARD,  
LITTLE ROCK, ARKANSAS**

## **SKILLS**

- Manager and Director for Respiratory Therapy for over 40 years.
- Always understanding and considerate of the needs of the Patient/Resident, as well as other fellow Health Care Providers.
- Enjoy providing quality Respiratory Care for the Patient/Resident, along with the fellow Health Care Providers.
- Pleasant personality with caring heart.

## **ACTIVITIES**

- Over the course of my career I have enjoyed working with and providing services for/or with the:
  - Arkansas/American Lung Association—providing meeting space and leading monthly educational meetings.
  - Cystic Fibrosis Foundation---organizing CF walks/runs to raise money for the Foundation.
  - Conway Human Development Center--- participate in fund raising walks, bowling activities, Special Olympics, etc.

Kenneth E. Rains  
Registered Respiratory Therapist Consultant  
2100 Hogan Lane, Conway, Arkansas 72034

Addendum to Resume: References

Services provided by Kenneth E. Rains to the following with the Contact Person listed:

August 1990--August 2014 as Part-time...August 2014--Present as Full-Time Consultant.

1. Conway Human Development Center  
150 East Siebenmorgen Road  
Conway, Arkansas 72032  
Contact Person: Jennifer Ethridge-Personnel Administrator  
Phone # 501-329-6851 Ext. 372  
E-mail Address: [Jennifer.ethridge@dhs.arkansas.gov](mailto:Jennifer.ethridge@dhs.arkansas.gov)

August 1980---August 2014 as Full-Time Director Respiratory Therapy Department.

2. Conway Regional Medical Center  
2302 College Avenue  
Conway, Arkansas 72034  
Contact Person: Richard Tyler- Human Resources  
Phone # 501-513-5311  
E-mail Address: [rt Tyler@conwayregional.org](mailto:rt Tyler@conwayregional.org)

May 2001---May 2013 as Part-Time Consultant

3. Apex Medical/Baker Drug  
924 Front Street  
Conway, Arkansas 72032  
Contact Person: Jim Hendrickson-Owner  
Phone # 501-329-5626  
E-mail Address: [hendricksonbakerdrug@yahoo.com](mailto:hendricksonbakerdrug@yahoo.com)

# University of Central Arkansas

has conferred upon

**Kenneth Eugene Rainz**

the degree of

**Bachelor of Science**

and all the Rights, Privileges and Honors thereto appertaining.

In Witness Whereof, this diploma duly signed has been issued and the seal of this University hereunto affixed.

Issued by the Board of Trustees upon recommendation of the Faculty at Conway, Arkansas.

August 11, 1978

Date

Wm. Charles E. Idem  
Chairman, Board of Trustees

Charles R. Allen  
Secretary, Board of Trustees



J. D. Jarvis  
President of the University

# School Of Health Sciences



Baptist Medical Center

To Whom All These Presents Come Greeting

Be it Known that

## Kenneth Eugene Rains

has completed the course of study required by this institution for professional practice in

### Respiratory Therapy

and is presented this certificate of accomplishment.

Little Rock, Arkansas, this 11th day of August A. D. 1978

*Wanda H. H. H.*

Clinical Instructor

Director  
School of Health Sciences

*J. R. Rains*  
Executive Director  
Baptist Medical Center System

# *The National Board For Respiratory Therapy*

Whereas Kenneth E. Pains  
has fulfilled the educational and experience requirements for  
qualification as a Respiratory Therapist, and has satisfactorily  
completed the written and clinical simulation examinations to  
demonstrate professional competence in this field,

Now, Therefore, The National Board for Respiratory Therapy  
hereby formally recognizes that he is a

*Registered Respiratory Therapist*

and is recorded in the Registry as number 9259

In Witness Whereof we have hereunto set our hands and seal this  
5th day of December, 19 79

President

William W. Dwyer

Secretary

Teng L. Steffen





**Arkansas Secretary of State  
John Thurston**

State Capitol Building ♦ Little Rock, Arkansas 72201-1094 ♦ 501-682-3409

**Certificate of Good Standing**

I, John Thurston, Secretary of State of the State of Arkansas, and as such, keeper of the records of domestic and foreign corporations, do hereby certify that the records of this office show


**KENNETH E. RAINS, LLC.**

authorized to transact business in the State of Arkansas as a Limited Liability Company, filed Articles of Organization in this office September 13, 1994.

Our records reflect that said entity, having complied with all statutory requirements in the State of Arkansas, is qualified to transact business in this State.



**In Testimony Whereof**, I have hereunto set my hand and affixed my official Seal. Done at my office in the City of Little Rock, this 23rd day of February 2021.

  
John Thurston  
Secretary of State  
Online Certificate Authorization Code: 0fd6e7939808e23  
To verify the Authorization Code, visit [sos.arkansas.gov](http://sos.arkansas.gov)

# Arkansas Taxpayer Access Point

File Franchise Tax Return

Welcome, Kenneth Rains

[Settings](#)[Log Off](#)[Home](#)[Acct: 58572594-FRN](#)[File Franchise Tax Return](#)

1. Demographics

## Demographics

### Franchise Return

Legal Name: KENNETH E. RAINS, LLC.

Account ID: 58572594-FRN

Filing Period: 12/31/2021

Due Date: 5/2/2022

### LLC Franchise Tax Return

#### Business

Organization Type  
Limited Liability Company ☒

SOS Filing Number

100115600

ID Type  
FEIN ☒

Federal Tax ID#

71-0761080

NAICS

Required

Name  
KENNETH E. RAINS, LLC.

#### Tax Contact Information

Tax Contact Name  
KENNETH E. RAINS LLCAddress  
2100 HOGAN LNAddress 2  
RequiredUnit Type  
Unit  
Contact Country  
USACity  
CONWAY

State

ARKANSAS

Zip Code  
72034-7964[Validate Address](#)☒ Verified?☐ Overridden?Phone # of Tax Contact  
(501)472-8382

E-mail Address

KRAINS@CONWAYCORP.NET

[Save Draft](#) [Cancel](#)[Next](#)[Department of Finance and Administration](#) | [FAQ](#)[Contact Us](#) | [Accessibility](#) | [Privacy](#) | [Security](#) | [Acceptable Use](#)



Mercer Consumer, a service of  
Mercer Health & Benefits Administration LLC  
P.O. Box 14576  
Des Moines, IA 50306-3576  
www.proliability.com

April 17, 2020

Kenneth Eugene Rains  
2100 Hogan Lane  
Conway, AR 72034

Re: Allied Health Professional Liability  
Customer Number: 638393  
Policy Number: AHY-626475009  
Expiration Date: 06/01/2021

Dear Kenneth Eugene Rains,

I am pleased to enclose your insurance policy through the Liberty Insurance Underwriters Inc. Please review the material carefully and take specific notice of any endorsements to the policy. These policy documents should be kept with your important papers.

Please note the important information below:

Address or Mid-Term Changes: Any change of address or request for mid-term change should be sent to the following address to assure timely receipt of future notices. All requests must be signed and dated by the policy holder. Also note that requests for mid-term changes to your coverage must be approved by an underwriter prior to binding coverage.

Mercer Consumer, a service of  
Mercer Health & Benefits Administration LLC  
P.O. Box 14576  
Des Moines, IA 50306-3576  
Fax: 212-948-1509  
Phone: 1-800-375-2764

If you have any questions, please contact our office Monday through Friday from 8:15 a.m. to 5:00 p.m. (CT). Thank you for the opportunity to serve your insurance needs.

Sincerely,

Mark Brostowitz  
Principal  
Mercer Consumer

Enclosure

Respiratory Therapist Self Employed  
Renewal Submission

NOTICE
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**CLAIM REPORTING INSTRUCTIONS**

In the event you receive notice of a **Claim, Suit, Incident or Occurrence**, you must provide written notice to Liberty Insurance Underwriters Inc. (LIUI). A claim must be reported to LIUI for assignment to a Claims Professional. Please follow the instructions below:

Please send written notice to:

[MercerClaims@libertyiu.com](mailto:MercerClaims@libertyiu.com)

OR

Liberty International Underwriters  
Attn: Mercer Claims  
55 Water Street 23rd Floor  
New York, NY 10041

If you would like to speak with someone regarding your **Claim, Suit, Incident or Occurrence**, please contact:  
**1-855-511-8097**

Terms in bold face are defined by your policy. Please refer to your policy for relevant definitions and reporting obligations.



## Healthcare Professional Liability

### LIBERTY INSURANCE UNDERWRITERS INC.

(A Stock Insurance Company, hereinafter the Company )

55 Water Street, 18<sup>th</sup> Floor

New York, NY 10041

#### DECLARATIONS

Policy Number: AHY-626475009

Renewal Of: AHY-626475008

#### SECTION I

##### Item

1. Named Insured: Kenneth Eugene Rains
2. Mailing Address: 2100 Hogan Lane  
Conway, AR 72034
3. Policy Period: From: 06/01/2020 To: 06/01/2021  
12:01 A. M. Standard Time At Location of Designated Premises
4. Business or Profession: Respiratory Therapist Affiliation: 3460-
5. The Named Insured is a(n):  
☐ Partnership ☐ Corporation ☒ Individual ☐ LLC  
☐ Sole Proprietor (with employees) ☐ Professional Association ☐ Other

This policy is made and accepted subject to the printed conditions of this policy together with the provisions, stipulations and agreements contained in the following form(s) or endorsements(s): HCPL-2037i (01/14), HCPL-2038 (11/09), HCPL-8101A (04/14)

HCPL-2037-9000-AR (11/09)

OFAC (08/09), TRIA-N004-0315, TRIA-E002-0315, HCPL-8003 (01/14),

HCPL-8320 (01/15), HCPL-8321 (01/15), HCPL-8324 (01/15), HCPL-8328 (02/15)

#### SECTION II

Item	COVERAGE	Premium
A.	Professional Liability [ X ]	\$148.00
B.	General Liability [ X ]	\$132.00
	Terrorism Risk Insurance Act [ X ]	\$0.00
C.	Endorsements [ ]	

TOTAL: \$280.00

#### LIMITS OF LIABILITY

\$1,000,000 Each Incident and Each Occurrence \$6,000,000 Aggregate

#### SECTION III

##### SUPPLEMENTARY PAYMENTS

- A. First Party Assault
- B. Licensing Board Reimbursement
- C. Wage Loss and Expense
- D. Deposition Expense
- E. First Aid Reimbursement

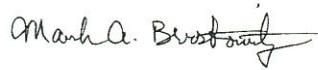
Representative Agent: Mercer Consumer, a service of  
Mercer Health & Benefits Administration LLC  
P.O. Box 14576  
Des Moines, IA 50306-3576


1 1

HCPL-2037D (11/09)



Client # 638393

<b>MEMORANDUM OF INSURANCE</b>				<b>Date Issued 04/17/2020</b>	
<b>Producer</b>  Mercer Consumer, a service of Mercer Health & Benefits Administration LLC P.O. Box 14576 Des Moines, IA 50306-3576 1-800-375-2764			This memorandum is issued as a matter of information only and confers no rights upon the holder. This memorandum does not amend, extend or alter the coverages afforded by the Certificate listed below.		
<b>Insured</b>  Kenneth Eugene Rains 2100 Hogan Lane Conway, AR 72034			<b>Company Affording Coverage</b> Liberty Insurance Underwriters Inc.		
This is to certify that the Certificate listed below has been issued to the insured named above for the policy period indicated, notwithstanding any requirement, term or condition of any contract or other document with respect to which this memorandum may be issued or may pertain, the insurance afforded by the Certificate described herein is subject to all the terms, exclusions and conditions of such Certificate. The limits shown may have been reduced by paid claims. The Memorandum of Insurance and verification of payment are your evidence of coverage. No coverage is afforded unless the premium is successfully paid in full.					
<b>Type of Insurance</b>	<b>Certificate Number</b>	<b>Effective Date</b>	<b>Expiration Date</b>	<b>Limits</b>	
Professional Liability Respiratory SE Respiratory Therapist	AHY-626475009	06/01/2020	06/01/2021	Per Incident/ Occurrence	\$1,000,000
				Annual Aggregate	\$6,000,000
<b>PROOF OF INSURANCE</b>					
Memorandum Holder:  <b>PROOF OF COVERAGE ONLY</b>			Should the above describe Certificate be cancelled before the expiration date thereof, the issuing company will endeavor to mail 30 days written notice to the Memorandum Holder named to the left, but failure to mail such notice shall impose no obligation or liability of any kind upon the company, its agents or representatives.		
			<b>Authorized Representative</b> Mark Brostowitz		
					

<b>MEMORANDUM OF INSURANCE</b>				Date Issued 04/17/2020	
<b>Producer</b>  Mercer Consumer, a service of Mercer Health & Benefits Administration LLC P.O. Box 14576 Des Moines IA 50306-3576 1-800-375-2764			This memorandum is issued as a matter of information only and confers no rights upon the holder. This memorandum does not amend, extend or alter <del>the</del> coverages afforded by the Certificate listed below.		
<b>Insured</b>  Kenneth Eugene Rains 2100 Hogan Lane Conway, AR 72034			<b>Company Affording Coverage</b> Liberty Insurance Underwriters Inc.		
This is to certify that the Certificate listed below has been issued to the insured named above for the policy period indicated, notwithstanding any requirement, term or condition of any contract or other document with respect to which this memorandum may be issued or may pertain, the insurance afforded by the Certificate described herein is subject to all the terms, exclusions and conditions of such Certificate. The limits shown may have been reduced by paid claims. The Memorandum of Insurance and verification of payment are your evidence of coverage. No coverage is afforded unless the premium is successfully paid in full.					
<b>Type of Insurance</b>	<b>Certificate Number</b>	<b>Effective Date</b>	<b>Expiration Date</b>	<b>Limits</b>	
<b>Professional Liability</b> Respiratory SE Respiratory Therapist	AHY-626475009	06/01/2020	06/01/2021	Per Incident/ Occurrence	\$1,000,000
				Annual Aggregate	\$6,000,000
<b>General Liability</b>	AHY-626475009	06/01/2020	06/01/2021	Per Incident/ Occurrence	\$1,000,000
				Annual Aggregate	\$6,000,000
Coverage includes General Liability occurrences at 2100 Hogan Lane Conway, AR 72034 but only as respects to claims arising out of the sole negligence of the Persons Insured under the provisions of this policy.					
<b>Memorandum Holder:</b>  PROOF OF COVERAGE ONLY			Should the above describe Certificate be cancelled before the expiration date thereof, the issuing company will endeavor to mail 30 days written notice to the Memorandum Holder named to the left, but failure to mail such notice shall impose no obligation or liability of any kind upon the company, its agents or representatives.		
			<b>Authorized Representative</b> Mark Brostowitz		
					

## CERTIFICATE OF NON-COVERAGE

This Certificate of Non-Coverage is issued under authority of Ark. Code Ann. §§ 11-9-102 (9) and 11-9-402(c). The certificate holder referenced below has applied for and obtained this Certificate and has lawfully elected to exclude the ☐ sole proprietor, ☐ partner(s), or ☒ member(s) of a limited liability company, as indicated below, from the mandatory insurance requirements of the Arkansas workers' compensation laws. The name(s) of the specific applicant(s) to be excluded from coverage under the workers' compensation laws is/are so listed; no other applicant is included in this authority without separate application.

This instrument certifies that the applicant(s) has/have complied with the Arkansas workers' compensation laws and has/have elected to not be covered by a policy of workers' compensation insurance in accordance with Ark.Code Ann. §§ 11-9-102(9) and 11-9-402(c).



*Jacquel D. Higgins*  
AWCC Compliance Officer





# ARKANSAS STATE MEDICAL BOARD

1401 West Capitol, Suite 340, Little Rock, Arkansas 72201 (501) 296-1802 FAX: (501) 603-3555

[www.armedicalboard.org](http://www.armedicalboard.org)

**Kenneth E. Rains, LRCP**  
2100 Hogan Lane  
Conway, AR, USA 72034


**Registration Year: 2020      Active/Unlimited**

**No.: RCP-1203      Issued: 6/10/1996      Expires: 7/31/2021**

**Below is your registration card to be carried with you.**

**You may make copies of this registration card, have them notarized and mail to any agency requiring registration verification.**

**You may return to this site at any time to notify this board of any address changes. Simply use the Change of Address link from the left-hand navigation menu found on your Account Home page. Name changes must be submitted in writing with supporting, legal documentation (i.e. marriage license or divorce decree).**

	<b>Arkansas State Medical Board</b> <b>1401 West Capitol, Suite 340</b> <b>Little Rock, AR 72201</b>
Registration Year: 2020      Active/Unlimited	
No.: RCP-1203      Issued: 6/10/1996      Expires: 7/31/2021	
Kenneth E. Rains, LRCP 2100 Hogan Lane Conway, AR, USA 72034	

BASIC LIFE SUPPORT		BASIC LIFE SUPPORT	
<b>BLS Provider</b>  <b>Kenneth Rains</b> has successfully completed the cognitive and skills evaluations in accordance with the curriculum of the American Heart Association Basic Life Support (CPR and AED) Program.		<b>Training Center Name</b> American First Response <b>Training Center ID</b> AR20304 <b>TC City, State</b> MAUMELLE, AR <b>TC Phone</b> (501) 771-1778 <b>Instructor Name</b> Bridgette Earls <b>Instructor ID</b> 05170572851	
<b>Issue Date</b> 4/4/2019	<b>Renew By</b> 04/2021	<b>eCard Code</b> 195503162957	
To view or verify authenticity, students and employers should scan this QR code with their mobile device or go to <a href="http://www.heart.org/cpr/mycards">www.heart.org/cpr/mycards</a> .		© 2020 American Heart Association 15-3001 R3/20	

#### Directions

1. Cut along dotted lines
2. Fold both halves together
3. Use adhesive to combine halves

Contract Number \_\_\_\_\_  
Attachment Number \_\_\_\_\_  
Action Number \_\_\_\_\_

Failure to complete all of the following information may result in a delay in obtaining a contract, lease, purchase agreement, or grant award with any Arkansas State Agency.

SUBCONTRACTOR: SUBCONTRACTOR NAME:

☐ Yes ☒ No

IS THIS FOR:

Goods? ☐ Services? ☒ Both? ☐

TAXPAYER ID NAME: Kenneth E. Rains

YOUR LAST NAME: Rains

FIRST NAME: Kenneth

M.I.: E.

Address: 2100 Hogan Lane

City: Conway

STATE:

AR

ZIP CODE: 72034

COUNTRY: USA

**AS A CONDITION OF OBTAINING, EXTENDING, AMENDING, OR RENEWING A CONTRACT, LEASE, PURCHASE AGREEMENT, OR GRANT AWARD WITH ANY ARKANSAS STATE AGENCY, THE FOLLOWING INFORMATION MUST BE DISCLOSED:**

### FOR INDIVIDUALS \*

Indicate below if: you, your spouse or the brother, sister, parent, or child of you or your spouse is a current or former: member of the General Assembly, Constitutional Officer, State Board or Commission Member, or State Employee:

Position Held	Mark (✓)		Name of Position of Job Held [senator, representative, name of board/ commission, data entry, etc.]	For How Long?		What is the person(s) name and how are they related to you? [i.e., Jane Q. Public, spouse, John Q. Public, Jr., child, etc.]	Relation
	Current	Former		From MM/YY	To MM/YY		
General Assembly							
Constitutional Officer							
State Board or Commission Member							
State Employee	✓		Rehab Instructor Supervisor	03/95	Present	Terresa N. Rains	Wife

☐ None of the above applies

### FOR AN ENTITY (BUSINESSES) \*

Indicate below if any of the following persons, current or former, hold any position of control or hold any ownership interest of 10% or greater in the entity: member of the General Assembly, Constitutional Officer, State Board or Commission Member, State Employee, or the spouse, brother, sister, parent, or child of a member of the General Assembly, Constitutional Officer, State Board or Commission Member, or State Employee. Position of control means the power to direct the purchasing policies or influence the management of the entity.

Position Held	Mark (✓)		Name of Position of Job Held [senator, representative, name of board/commission, data entry, etc.]	For How Long?		What is the person(s) name and what is his/her % of ownership interest and/or what is his/her position of control?	Ownership Interest (%)	Position of Control
	Current	Former		From MM/YY	To MM/YY			
General Assembly								
Constitutional Officer								
State Board or Commission Member								
State Employee								

☒ None of the above applies

Contract Number \_\_\_\_\_  
Attachment Number \_\_\_\_\_  
Action Number \_\_\_\_\_

## Contract and Grant Disclosure and Certification Form

**Failure to make any disclosure required by Governor's Executive Order 98-04, or any violation of any rule, regulation, or policy adopted pursuant to that Order, shall be a material breach of the terms of this contract. Any contractor, whether an individual or entity, who fails to make the required disclosure or who violates any rule, regulation, or policy shall be subject to all legal remedies available to the agency.**

**As an additional condition of obtaining, extending, amending, or renewing a contract with a state agency I agree as follows:**

1. Prior to entering into any agreement with any subcontractor, prior or subsequent to the contract date, I will require the subcontractor to complete a **CONTRACT AND GRANT DISCLOSURE AND CERTIFICATION FORM**. Subcontractor shall mean any person or entity with whom I enter an agreement whereby I assign or otherwise delegate to the person or entity, for consideration, all, or any part, of the performance required of me under the terms of my contract with the state agency.
2. I will include the following language as a part of any agreement with a subcontractor:  
  
*Failure to make any disclosure required by Governor's Executive Order 98-04, or any violation of any rule, regulation, or policy adopted pursuant to that Order, shall be a material breach of the terms of this subcontract. The party who fails to make the required disclosure or who violates any rule, regulation, or policy shall be subject to all legal remedies available to the contractor.*
3. No later than ten (10) days after entering into any agreement with a subcontractor, whether prior or subsequent to the contract date, I will mail a copy of the **CONTRACT AND GRANT DISCLOSURE AND CERTIFICATION FORM** completed by the subcontractor and a statement containing the dollar amount of the subcontract to the state agency.

**I certify under penalty of perjury, to the best of my knowledge and belief, all of the above information is true and correct and that I agree to the subcontractor disclosure conditions stated herein.**

Signature Kenneth E. Rains Digitally signed by Kenneth E. Rains  
Date: 2021.03.05 08:22:04 -06'00' Title Owner/Sole Proprietor Date 03/05/21

Vendor Contact Person Kenneth E. Rains Title Owner/Sole Proprietor Phone No. (501) 472-8382

*Agency use only*  
Agency Number 0710 Agency Name Department of Human Services Agency Contact Person \_\_\_\_\_ Contact Phone No. \_\_\_\_\_ or Grant No. \_\_\_\_\_