**Attachment 3 (Revised)**

**NEW YORK STATE DEPARTMENT OF HEALTH**

**Communicable Disease and Infection Control Surveillance & Investigation**

**Cost Proposal Form**

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| Organization Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   Check Region for Bid: \_\_\_\_\_\_\_\_\_\_\_ Upstate Region \_\_\_\_\_\_\_\_\_\_ Downstate Region  IFB# : 16550  Contract Period: 08/01/16 – 07/31/21 |

|  |  |
| --- | --- |
| List Year | Hourly Rate Per Staff |
| Year 1: |  |
| Year 2: |  |
| Year 3: |  |
| Year 4: |  |
| Year 5: |  |

|  |  |
| --- | --- |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of Bidder’s Authorized Representative  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Title of Authorized Representative | \_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_ / \_\_\_\_\_\_\_\_  Date  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phon Number |