**Attachment 3 (Revised)**

**NEW YORK STATE DEPARTMENT OF HEALTH**

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

**Cost Proposal Form**

|  |
| --- |
| Organization Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Check Region for Bid: \_\_\_\_\_\_\_\_\_\_\_ Upstate Region \_\_\_\_\_\_\_\_\_\_ Downstate RegionIFB# : 16550Contract 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 |