# INSTRUCTIONS

### Form Instructions:

Complete this form electronically. Do not complete this form by hand.

### E-Mail a copy of thE COMPLETED form AND ATTACHMENTS to:

Joan.Archie@uchospitals.edu

### FORWARD AN ADDITIONAL signed COPY TO:

UNIVERSITY OF CHICAGO MEDICAL CENTER

Facilities Planning, Design, & Construction

Construction Compliance

850 E. 58th St

Chicago, Illinois 60637

ATTN: Joan Archie, Executive Director, Construction Compliance

# CAPABILITY – SERVICES

## 1. PRIMARY SERVICE CATEGORY

Please select only **one (1) primary service category** below that will apply to your pre-qualification application.

[ ]  Architect

[ ]  Engineer

[ ]  Consultant

## 2. SECONDARY SERVICE CATEGORIES

Please select the **service(s)** provided by your company below.

[ ]  Accessibility

[ ]  Adaptive Reuse

[ ]  Asbestos Abatement

[ ]  Audio Visual

[ ]  Building Envelope

[ ]  Civil Engineering

[ ]  Code Analysis

[ ]  Code Estimating

[ ]  Commissioning

[ ]  Decorating

[ ]  Design Architect

[ ]  Engineering – Mechanical

[ ]  Engineering – Electrical

[ ]  Engineering – Plumbing

[ ]  Engineering – Fire Protection

[ ]  Equipment Planning

[ ]  Façade Forensics

[ ]  Facility Assessments

[ ]  Feasibility Studies

[ ]  Food Service Design & Planning

[ ]  Fire Protection

[ ]  Furniture

[ ]  Graphics & Branding

[ ]  Historic Preservation

[ ]  HVAC

[ ]  Interior Design

[ ]  Interior Renovation

[ ]  Lab Design and Planning

[ ]  Master Planning

[ ]  Operational Analysis

[ ]  Pharmacy Design and Planning

[ ]  Project Management

[ ]  Programming

[ ]  Program Management

[ ]  Roofing/Waterproofing

[ ]  Scope Assessment

[ ]  Site Planning

[ ]  Surveying

[ ]  Sustainable Design

[ ]  Transition Planning

[ ]  Vertical Transportation

[ ]  Wind Studies

# ADMINISTRATIVE

## 1. BUSINESS INFORMATION

|  |  |
| --- | --- |
| FULL LEGAL NAME OF APPLICANT: |       |
| Street, PO Box: |      ,       |
| CITY, STATE, ZIP: |      ,      ,       |
| cITY, STATE, zIP OF aPPLICANT’S CLOSEST OFFICE TO THE UNIVERSITY OF CHICAGO MEDICAL CENTER: |      ,      ,       |
| [ ]  TAX I.D. or[ ]  S.S. NUMBER: |       |
| NUMBER OF YEARS IN BUSINESS UNDER CURRENT LEGAL NAME  |       |
| COMPANY WEBSITE: |       |
| APPLICANT CONTACT’S FIRST and LAST NAME: |             |
| APPLICANT CONTACT’S TITLE: |       |
| APPLICANT CONTACT’S WORK PHONE: |       |
| APPLICANT CONTACT’S CELL PHONE: |       |
| BID INVITATION FAX NUMBER: |       |
|  BID INVITATION CORPORATE EMAIL ADDRESS: |       |

List other or former names along with timeframes which your organization has operated as a contractor below:

### Company Name Year(s)

## 2. ORGANIZATIONAL STRUCTURE

Please select the company’s organizational structure and complete the corresponding information.

[ ]  Corporation:

 State of Incorporation:  Year:

[ ]  Subsidiary / Division of:

 Headquarters Address:

 City, State, Zip:

 DUNS Number:

[ ]  Parent Company to:

List Subsidiaries & Divisions

**If a separate tax I.D. number applies to a company division or subsidiary, a separate application must be submitted for each business entity.**

[ ]  Partnership

[ ]  General [ ]  Limited

State & Country where filed: ,

Date of Organization:

[ ]  Individual Proprietorship

Date of Organization:

## 3. KEY COMPANY PERSONNEL

List below the key officers in your organization:

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **First Name** | **Last Name** | **Title** | **Telephone** | **Cell Phone** | **FAX** | **Email** |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
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|  |  |  |  |  |  |  |

List below primary external and/or internal contractor representative(s) that will be dedicated to handling project customer service and management related issues for the University of Chicago Medical Center.

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **First Name** | **Last Name** | **Title** | **Telephone** | **Cell Phone** | **FAX** | **Email** | **Responsibilities** |
|  |  |  |  |  |  |  |  |
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Provide resumes for the company officers and key individuals of your organization indicating past and present experience. **Include as Attachment B. Resumes of Key Personnel**

## 4. PROFESSIONAL/TECHNICAL AFFILIATIONS AND LICENSING

List all memberships and associations to professional and trade organizations and trade unions the company has:

## 5. LIABILITY INSURANCE

University of Chicago Medical Center General Conditions require the following minimum limits of general liability insurance.

|  |  |  |
| --- | --- | --- |
|   | Item  | Minimum  |
|  | Commercial General LiabilityAutomobile LiabilityWorker’s CompensationEmployer’s Liability Professional Liability | $2,000,000 $1,000,000 As Required by Law$500,000$1,000,000 |

Confirm below that your company can provide a certificate of insurance with these limits if awarded a project.

For UCMC Projects [ ]  Yes [ ]  No

 Name of Agency:

 Name of Agent:

 Address:

 Phone:

 FAX:

 Email:

# CAPABILITY – PROJECT EXPERIENCE

### 1. PROJECT EXPERIENCE

List all major projects relevant to healthcare and sciences your company has in progress or has completed in the past five years based out of your closest office to UCMC. Provide the project name, primary project type, owner’s organization name, GC/CM/specialty contractor name, your contract amount, start date, (scheduled) completion date, and % complete. **Include as Attachment C. Major Project Listing**

### 2. UCM & UC PROJECT EXPERIENCE

List all University of Chicago Medical Center and University of Chicago projects relevant to healthcare and sciences your company has performed in the past five years. Provide the project name, project number, primary project type, primary building name/location, UCM/UC, UCM/UC project manager, GC/CM/Specialty contractor name, your contract amount, start date, (scheduled) completion date, and % complete.

**Include as Attachment D. UCM & UC Major Project Listing**

# CAPACITY

## 1. PERCENTAGE BREAKDOWN OF REVENUES BY YEAR

For the past five years, what percentage of your company’s revenues were generated by performing the following services: (Please provide information for at least one of the services)

 Year Year Year Year Year

 20 20 20 20 20

[ ]  Architect % % % % %

[ ]  Engineer % % % % %

[ ]  Consultant % % % % %

 Totals 100% 100% 100% 100% 100%

## 2. PERCENTAGE BREAKDOWN BY PROJECT CATEGORY

In the past 5 years, what percentage of your total workload was for the following categories:

Institutional % Institutional Subcategories (Total must equal 100%)

Commercial % Hospital/Healthcare %

Residential % Laboratory %

Industrial % Classroom %

 Total: 100 % Office %

 Food Service %

 Parking Structure %

 Other %

## 3. PROJECT SIZE CAPABILITIES

What size jobs would your firm prefer to bid? Minimum and maximum are the value of the Architect/Engineer/Consultant’s contract and not construction cost of the project.

 Minimum $ Maximum $

State annual dollar amount of work performed during the past five years:

 Year: 20 20 20 20 20

 Total

 Amount: $ $ $ $ $

## 4. PERSONNEL BREAKDOWN BY JOB CLASSIFICATION

Total number of full time personnel working in healthcare and sciences division: #

Project Architect/Engineer working in healthcare and sciences division: #

Architect/Engineer working in healthcare and sciences division: #

Junior Designer/Engineer working in healthcare and sciences division: #

**PERFORMANCE**

## 1. LEGAL CLAIMS AND SUITS

Has your organization ever defaulted on a contract? [ ]  Yes [ ]  No

Are there any judgments, claims, arbitration proceedings or suits pending or outstanding against your organization

or its officers? [ ]  Yes [ ]  No

Has your organization filed any lawsuits or claims with regard to construction contracts within the last five years? [ ]  Yes [ ]  No

**If the answer is yes to any of the above questions, please provide details and include in Attachment A. Supplemental Information.**

## 2. PROJECT REFERENCES

 Reference 1: Reference 2: Reference 3:

Name:

Title:

Company:

Address:

Phone:

FAX

Email

## 3. SUBCONSULTANT REFERENCES

 Reference 1: Reference 2: Reference 3:

Name:

Title:

Company:

Address:

Phone:

FAX

Email

## 4. FINANCIAL REFERENCES

 Reference 1: Reference 2: Reference 3:

Name:

Title:

Company:

Address:

Phone:

FAX

Email

 **ATTACHMENTS**

**Attachment A - Supplemental Information**

**Attachment B - Resumes of Key Personnel**

**Attachment C - Major Project Listing**

**Attachment D - UC & UCMC Major Project Listing**

**Attachment E – Not Used for This Application**

**Attachment F - Acknowledgement and Authorization Form**

**Attachment G - Checklist for Completed Information and Required Attachments**

## Attachment F:

## ACKNOWLEDGEMENT & AUTHORIZATION FORM

## THE UNIVERSITY OF CHICAGO MEDICAL CENTER

## FACILITIES PLANNING, DESIGN & CONSTRUCTION

The undersigned hereby acknowledges that he or she has read and understands the instructions and requirements as requested within this Application for Pre-qualification.

By signing below, the undersigned acknowledges that he or she is a duly authorized, expressed agent of the company listed below and as such agrees with the validity and accuracy of all provided information as to the best of their knowledge.

The Applicant

Dated this day of , 20

Name of Organization:

Title of Applicant:

Name of Applicant:

By:

 (Signature)

## Attachment G:

## CHECKLIST FOR COMPLETED INFORMATION AND REQUIRED ATTACHMENTS

All Sections within this checklist must be completed and returned with your Application. As each item is completed, place a checkmark next to the referenced Section.

By checking the box within the checklist, you confirm that you have completed the information, including the required Attachments as requested in the Application document.

If any Section is not checked, an explanation must be provided within Attachment A and returned with your Application. Otherwise, your Application will be considered incomplete and will not be given further consideration.

**Sections Requiring Completion Checklist for Completing Requirements**

|  |  |
| --- | --- |
| **CAPABILITY** |  |
| 1. Primary Service Categories | [ ]  One (1) primary service category checked only. |
| 2. Secondary Service Categories | [ ]  Selected secondary service categories. |
| **ADMINISTRATIVE** |  |
| 1. Business Information | [ ]  All fields complete |
| 2. Organizational Structure | [ ]  At least one checkbox and corresponding fields complete. |
| 3. Key Company Personnel | [ ]  All fields complete[ ]  **Attachment B – Resumes of Key Personnel** |
| 4. Professional/Technical Affiliations & Licensing | [ ]  Any and all affiliations/licensing listed |
| 5. Liability Insurance | [ ]  Confirmation (Yes) of ability to provide certificate of insurance.[ ]  All fields complete for insurance agency information.  |
| **CAPABILITY – PROJECT EXPERIENCE** |  |
| 1. Project Experience | [ ]  All project information included per instructions.[ ]  **Attachment C - Major Projects Listing complete.** |
| 2. UC & UCMC Project Experience | [ ]  All information included per instructions for UC/UCM projects. [ ]  **Attachment D – Major UCM & UC Projects Listing complete.**  |
| **CAPACITY** |  |
| 1. Percentage Breakdown of Revenues by Year | [ ]  Each column complete and totals 100% |
| 2. Percentage Breakdown by Project Category | [ ]  Each column complete and totals 100% |
| 3. Project Size Capabilities | [ ]  Both minimum and maximum dollar amounts complete.[ ]  Annual dollar amounts complete for each year in business.  |
| 4. Personnel Breakdown by Job Classification | [ ]  All fields complete |
| **PERFORMANCE** |  |
| 1. Legal Claims and Suits | [ ]  All checkboxes complete[ ]  **Attachment A - Supplemental Information, if applicable.** [ ]  Claims and Lawsuit Details or [ ]  Not Applicable |
| 2. Project References | [ ]  All fields complete. |
| 3. Sub-consultant References | [ ]  All fields complete.  |
| 4. Financial References | [ ]  All fields complete. |