# NTP LOGOLogo DMC Logo

**VENDOR REGISTRATION FORM**

***[ Common unit to Manage Global Fund Grants HIV, TB & Malaria, Ministry of National Health Services Regulation & Co-ordination]***

|  |  |
| --- | --- |
| **Vendor’s Category****(*to be mentioned by Vendor*)** |  |
| **Note: Please see Annexure II for vendor’s registration category** |

|  |
| --- |
| **Procurement & Supply Chain Management Unit****Common Unit to Manage Global Fund Grants HIV/AIDS. TB & Malaria** |
| **Date Received by PSCM Unit** |  |
| **Name / Designation of Receiver** |  |
| **Date Evaluated** |  |
| **Registration intimated on** |  |
| **Rejection intimated on** |  |

**General Instructions**

Vendors interested in becoming registered with CMU PR-GFATM HIV/AIDS, TB & MALARIA must pre-register with the Procurement and Supply Chain Management unit. This registration process is mandatory and supersedes all previous registration. This registration shall be valid for “3“years, thereafter, it is the vendor’s responsibility to renew their registration in a timely manner at least 3 months ahead of expiry. All new and existing vendors are required to register by completing this form and submit along with it the documents mentioned in the following checklist. If any of the documents are not included with the form, the reason for the same shall be mentioned in the remarks section.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **S. No.** | **Document** | **Incl.** | **Excl.** | **N/A** | **Remarks** |
| 1. | Firm registration and incorporation  |  |  |  |  |
| 2. | Valid NTN and GST certificate |  |  |  |  |
| 3. | Any Professional Registratione.g Printing press reg. etc |  |  |  |  |
| 4. | Bankers certificate  |  |  |  |  |
| 5. | Affidavit that the company has never been black listed.  |  |  |  |  |
| 6. | Copies of valid foreign Agency Agreement/dealership/ distributorship, if applicable. |  |  |  |  |
| 7. | Past experience: enlistment with different departments |  |  |  | Please share client list with year of registration with them.Please submit details as per need mentioned evaluation criteria points 1,2 &3. |
| 8. | All pages of this registration form & related documents must be signed and stamped by the authorized signatory. |  |  |  |  |

All parts of the registration form must be completed, and all above requirement must be fully complied with.

Registration with CMU PR-GFATM HIV/AIDS, TB & MALARIA, if accepted, does not constitute any obligation by CMU PR-GFATM Programme to guarantee any tender invitation, contractual awards or any order for product or service.

Incomplete application and/or missing information shall not be dealt with; all queries regarding registration should be directed to Procurement and Supply Chain Management unit on Telephone **No. 051-9255621 & email at psm@nacp.gov.pk**

All parts of this registration form must be completed; incomplete forms will not be processed. Please see Annexure I,II & III for declaration affidavit, vendor registration category and evaluation criteria.

**Part 1 Purpose - Please tick as appropriate.**

|  |
| --- |
| * NEW REGISTRATION
* Change of Name/Address
* Add Product or Service Categories
* Delete Product or Service Categories
* Renewal of Registration
* Others, Please specify \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |

**Part 2 – Official Name/ Address/ Contact details (Legally binding)**

|  |
| --- |
| **Name of VENDOR \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **(Legal name as in INCORPORATION /NTN/GST CERTIFICATE)****Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****SECTOR \_\_\_\_\_\_\_\_\_\_\_\_\_ =Street \_\_\_\_\_\_\_\_\_\_****City/Town \_\_\_\_\_\_\_\_\_\_\_\_\_ =Postal code \_\_\_\_\_\_\_\_\_\_** **Country \_\_\_\_\_\_\_\_\_\_\_\_\_\_****Telephone No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Telephone Nos for urgent contacts****Mobile No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****Fax No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****E-mail Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **SALES TAX REGISTRATION NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****NATIONAL TAX NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

**Part 3 – Type of Organization**

|  |
| --- |
| * Corporation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Limited liability Co. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Partnership \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Sole proprietorship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Other ( specify ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 |

**Part 4 – Ownership**

|  |
| --- |
| Please Specify Owner/Partners/Shareholders Name/Names with Share Percentage. Name Share % \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_Mr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Mr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Mr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Mr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Mr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Part 5 – Technical Support Staff**

|  |  |  |
| --- | --- | --- |
| **S.No** | **Designation/Position** | **No. of Staff** |
| 1 |  |  |
| 2 |  |  |
| 3 |  |  |
| 4 |  |  |

**Part 6 – Firm Remit Details (For payment purposes).**

|  |
| --- |
|  If the information to be provided in the part is same as provided in Part 2, please skip to the next part, else please complete the following.Name, Remit To \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Address, Remit To \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sector \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Telephone Nos. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Contact Person. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Part 7 – Details of your Bankers (For payment purposes).**

|  |
| --- |
|   1. Name of Bank \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BANK ACCOUNT NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_2. Name of Bank \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BANK ACCOUNT NO \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_3. other banks \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Part 8 – Certificates Validity.**

|  |  |  |  |
| --- | --- | --- | --- |
| **S.No** | **Dealership Description**  | **Product Name** | **Expiry** **Date** |
| 1 |  |  |  |
| 2 |  |  |  |
| 3 |  |  |  |
| 4 |  |  |  |

**Part 10 – Relatives / Employees of CMU PR-GFATM HIV/AIDS, TB & MALARIA**

|  |
| --- |
| Please tick, if you are an ex-CMU PR-GFATM HIV/AIDS, TB & MALARIA employeeList firm officers or Principles who are CMU PR-GFATM HIV/AIDS, TB & MALARIA employees or related to CMU PR-GFATM HIV/AIDS, TB & MALARIA employees.**Please Tick If Applicable None**1**.** Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Position \_\_\_\_\_\_\_\_\_\_\_ Department \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_**2.** Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Position \_\_\_\_\_\_\_\_\_\_\_ Department \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_ |

**Annexure-I**

**DECLARATION**

**[ Please submit on company letter head]**

 I, the undersigned, Mr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorized on behalf of Messrs \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, declare and confirm that the information provided herein is true, accurate and correct. I agree that this registration, if accepted, shall be valid for three years from the date of approval and it does not constitute an assumed obligation whatsoever by CMU PR-GFATM HIV/AIDS, TB & MALARIA. I also confirm that in the event of any changes of status or changes in the elements of the aforementioned information, details shall be provided as and when changes take place.

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Signature Date**

**Name: - \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Designation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **Annexure-II**

**Vendor Category List.**

|  |  |  |
| --- | --- | --- |
| **S.No.** | **Category Name** | **Comments** |
| 1 | Laboratory Supplies -lab chemical, reagents, consumables etc  |  |
| 2 | Laboratory Equipment |  |
| 3 | Printing |  |
| 4 | Advertising / Event Management |  |
| 5 | IT Equipment |  |
| 6 | Office Furniture  |  |
| 7 | Travel, air ticketing & Rent a Car |  |
| 8 | Incineration Services |  |
| 9 | Firefighting equipment |  |
| 10 | HVAC Installation repair maintenance  |  |
| 11 | Generator, A.C repair and maintenance  |  |
| 12 | Stationery & General Items |  |
| 13 | Insurance Services  |  |
| 14 | Office Equipment Repairing |  |
| 15 | Vehicle Repair & Maintenance |  |
| 16 | Laboratory Equipment Repairing and Validation |  |
| 17 | Courier Services  |  |
| 18 | Infrastructure Up-Gradation |  |
| 19 | Consultancy Services – in technical areas of programmes  |  |
| 20 | Hotel & Restaurants |  |
| 21 | Janitorial Services |  |
| 22 | Drinking water |  |
| 23 | Plumbing & Electrification work |  |

**Chief Procurement Officer**

**PSCM Unit CMU PR-GFATM, C-Block, EPI Building, Park Road Chak Shahzad, Islamabad.**

**Phone No. 051-9255621-2**

 **Annexure-III**

**VENDOR EVALUATION FORM**

**Vendor Business Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Category Applied for\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone No: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Postal Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |
| --- | --- | --- | --- |
| **S.NO** | **CRITERIA** | **SCORE RANGE** | **ASSESSED****SCORE** |
| **Weak** | **Strong** | **Out-****Standing** |
| 1 | **Past Experience (Tenure in Business for applied category)** | **2-5 Years** | **2-10 Years** | **Above 10 Years** |  |
| Allotted Points | 5 | 10 | 15 |  |
| 2 | Experience with Public sector organization(s) | **2-5 Years**5 | **2-10 Years**10 | **Above 10 Years**15 |  |
| 3 | Experience with iNGO/Doner Agencies  | **2-5 Years**5 | **2-10 Years**10 | **Above 10 Years**15 |  |
| 4 | **Technical Support** (No. of persons Who can provide technical expertise to CMU PR-GFATM HIV/AIDS, TB & MALARIA) | **1 No** | **2 No** | **3 or above No** |  |
| Allotted Points | 5 | 10 | 15 |  |
| 5 | **Contact numbers in case of urgency** | **1 No.** | **2 Nos** | **3 or above Nos** |  |
|  |  |  |  |  |
| Allotted Points | 10 | 15 | 20 |  |
| 6 | **Convenient to Approach from office** | **Out of twin cities Rawalpindi/Islamabad** | **Within Rawalpindi** | **Within a Islamabad -ICT** |  |
| Allotted Points | 10 | 15 | 20 |  |
|  | **TOTAL SCORE** | **45** | **70** | **100** |  |

**Cut off point to be eligible for registration is “70”**

**Recommendations/Remarks:………….……..………………………………………………..……………………………………….…………………**

**Evaluation Committee:**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Designation** | **Date** | **Signature** |
| **Prepared by** |  |  |  |  |
| **Reviewed by** |  |  |  |  |
| **Approved by** |  |  |  |  |
| **VENDOR CODE (If approved)**  |  |  |
| Vendor information entered by |  |  Vendor created in system on |  |