**Attachment 5**

**Submission Form for**

**Technical Proposal**

**(Full Service)**

1. Proposer’s name, address, telephone and fax numbers, email and federal tax identification number.

|  |  |
| --- | --- |
| Firm (Legal Name): |  |
| Address: |  |
| Address Line 2: |  |
| City, State, Zipcode |  |
| Contact: |  |
| Title: |  |
| Phone Number: |  |
| Fax Number: |  |
| Email Address: |  |
| Federal Tax ID Number: |  |

1. Estimated Meeting and Function Room Block:

 Propose Meeting and Function Rooms schedule. A description of the set is detailed below. Please add the Function room name, square footage, noting dimensions, any odd shapes, angles, pillars and other salient characteristics). Enter “n/a” for any items that are not applicable.

| **Time** | **Function** | **Set Up** | **Expected Attendance** | **Room Name****Sq. Footage** |
| --- | --- | --- | --- | --- |
| **Sunday, September 9, 2012** |
| 2:00 pm – 8:00 pm | Faculty Meeting | Boardroom orConference | 5 |  |
| 2:00 pm – 8:00 pm | Faculty Meeting | Boardroom orConference | 5 |  |

Are Meeting and Function Rooms compliant with American Disabilities Act (ADA)?

|  |  |
| --- | --- |
| Yes |  |
| No |  |

1. Propose Sleeping Room schedule. Enter “n/a” for any items that are not applicable.

| Date | Type of Sleeping Room | Estimated Number of Sleeping Rooms | Requested Upgrades at Group Rate | Confirm Number of Rooms able to provide | Confirm Number of Upgrades able to provide |
| --- | --- | --- | --- | --- | --- |
| Sunday,September 9 | Single/Double Occupancy | 90 | 0 |  | N/A |
| Monday,September 10 | Single/Double Occupancy | 90 | 0 |  | N/A |
| Tuesday, September 11 | Single/Double Occupancy | 90 | 0 |  | N/A |
| Wednesday,September 12 | Single/Double Occupancy | 70 | 0 |  | N/A |
| Thursday,September 13 | Single/ Double Occupancy | 70 | 0 |  | N/A |
|  |  | 410 | 0 |  |  |

Are Sleeping rooms compliant with American Disabilities Act (ADA)?

|  |  |
| --- | --- |
| Yes |  |
| No |  |

1. Propose the cut-off date for reservations:
2. Propose cancellation deadline for individual reservations:
3. Other Program Needs (identify if included in other proposed pricing):

| Item No. | Description | Approved (please note if approved) | ProposedAmount  |
| --- | --- | --- | --- |
| 1. | Complimentary room policy – please indicate how many booked rooms will earn 1 complimentary room. |  |  |
| 2. | Extend sleeping room rate pre and post program – please indicate how many days room rate can be extended. |  |  |

1. Propose options for transportation to the hotel on public transportation

Discuss the various means of transportation to local airports.

|  |
| --- |
| Discuss the approximate distance from major freeways. |
|  |

**H. Signature (must be completed by proposer):**

|  |
| --- |
| Signed this \_\_\_\_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ , 20\_\_\_\_\_\_\_\_. |
| By: |  |  |  |
|  | Signature |  | Print Name |
| Title: |  |  |  |