**1.3\_FORMS REGARDING THE SELECTION CRITERIA**

**1.3.1\_LEGAL ENTITY FILE**

**PLEASE COMPLETE AND SIGN THIS FORM AND**

**ATTACH COPIES OF OFFICIAL SUPPORTING DOCUMENTS\***

*(Please use CAPITAL LETTERS and LATIN CHARACTERS when filling in the form)*

**PRIVATE/PUBLIC LAW BODY WITH LEGAL FORM**

**OFFICIAL NAME**

**ABBREVIATION (if apply)**

**LEGAL FORM**

**ORGANIZATION TYPE: o FOR PROFIT o NON FOR PROFIT**

**TYPE OF BUSINESS:**

**PRIMARY COUNTRY OF OPERATION:**

**\*SOUTH SUDAN COMPANY REGISTRATION NUMBER**

**DATE OF THIS COMPANY REGISTRATION CERTIFICATE**

***The date has to be the proof of Legal establishment for a minimum of 6 months from SS authorities certification***

***\*\*\*\*\*To be attached the Country Registration Certificate\*\*\*\*\****

**ADDRESS OF HEAD OFFICE**

**CITY**

**COUNTY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**STATE**

**POSTCODE**

**P.O. BOX**

**COUNTRY**

**PHONE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**E-MAIL \_**

**PRODUCT CATEGORY SUPPLIED**

**DATE**

**SIGNATURE and NAME OF AUTHORISED REPRESENTATIVE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**STAMP**

**1.3.2\_ECONOMICAL AND FINANCIAL CAPACITY**

**Please provide all of the information required in USD to fill in the next requested info, to obtain a positive evaluation you have fill in the Financial Identification Form with the related attachment and reach at least the score of 16**

1. **Annual turnover for the last three years in South Sudan attaching the most official document available as proof:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **USD** | **Year-3 (2021)** | **Year-2 (2022)** | **Last year (2023)** | **Average**  |
| in SOUTH SUDAN |  |  |  |  |

15 points for an average of more than 150.000 USD?

10 points for an average between 100.000 USD and 150.000 USD?

 5 points for an average between 100.000 USD and 50.000 USD?

1. points for an average lower than 50.000 USD?
2. **Relevant Work Experience for similar goods supplied in the period 2022 - 2023:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **NR** | **Invoices / contract with total value higher than 20.000USD for:** | **Name of Client and contact** | **Date of invoices / contract** | **Items supplied amount** |
| 1 | Drugs and other medical items Supplied or similar? To be specified |  |  |  |
| 2 | Drugs and other medical items Supplied or similar? To be specified |  |  |  |
| 3 | Drugs and other medical items Supplied or similar? To be specified |  |  |  |
| 4 | Drugs and other medical items Supplied or similar? To be specified |  |  |  |
| 5 | Drugs and other medical items Supplied or similar? To be specified |  |  |  |

15 points for more than 4 invoice/contract higher than 20.000USD

10 points for 3- 4 invoice/contract higher than 20.000USD

 5 points for 1 -2 invoice/contract higher than 20.000USD

 0 points for no invoice/contract higher than 20.000USD

1. **Bank information**

|  |  |  |
| --- | --- | --- |
| **NR** | **Bank Name and address (branch)** | **Financial Identification form\* filled in and signed,** **attaching a Copy of the most recent Bank Statement\*\***  |
| 1 |  | YES / NO |
| 2 |  | YES / NO |
| 3 |  | YES / NO |

***\*The Financial Identification is available below***

***\*\*Attachement to be included in the present form***

**This document is biding to administrative compliance with this criteria selection.**

**If you don’d submit it, the offer will be not taken into consideration**

1. **Other information**

|  |  |
| --- | --- |
| **Provide details of what insurance cover you have and what the maximum value is*****(TO BE ATTACHED A DECLARATION OF COMPANY INSURANCE / VALID DOCUMENT AS PROOF OF INFORMATION)*** |  |

Max. 10 points for a maximum of more than 50.000 USD value covered by the company insurance

Signature: .................................................................................. Date: …………………………………….

**\*FINANCIAL IDENTIFICATION FORM**

**attachment to 1.3.2\_c)**

**PLEASE COMPLETE AND SIGN THIS FORM ATTACHING A RECENT COPY BANK STATEMENT**

*(Please use CAPITAL LETTERS and LATIN CHARACTERS when filling in the form)*

**BANKING DETAILS**

**ACCOUNT NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**IBAN/ACCOUNT NUMBER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CURRENCY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**BIC/SWIFT CODE BRANCH CODE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**BANK NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

ADDRESS OF BANK BRANCH

**STREET & NUMBER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**TOWN/CITY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**POSTCODE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**COUNTRY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

ACCOUNT HOLDER'S DATA AS DECLARED TO THE BANK

**ACCOUNT HOLDER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**STREET & NUMBER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**TOWN/CITY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**POSTCODE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**COUNTRY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**REMARK \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SIGNATURE OF ACCOUNT HOLDER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**1.3.3\_ Technical and professional capacity**

**To obtain a positive evaluation you have to attach the requested PO/Purch. Ref and reach at least the score of 60.**

1. **Length of Service and structure of Company**

Length of service will be calculated from oldest purchase order available.

**How long your company is active in South Sudan with the supply of Drugs, medical supplies and Equipment?**

**Indicate the date of oldest purchase order received from your clients for supply of Drugs, medical supplies and Equipment in South Sudan\*:**

**Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Years \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *(from the date indicated to today)***

***\* Need to submit the PO/Reference with contact details as supporting document***

|  |  |
| --- | --- |
| **Company structure information requested** | **Reply from the supplier** |
| 1. When the supplier organization was founded?
 |  |
| 1. Specify the origins and historical development
 |  |
| 1. Details of any parent company, if applicable
 |  |
| 1. Details of joint venture arrangements (if applicable)
 |  |
| 1. Details of key health and safety, environmental and other performance measures applied by the Company
 |  |

Max. 10 points for ≥ 5 years and each individual year 2 points.

0 points for minimum experience less than 24 MONTHS.

The info requested for the structure can give you a maximum of 10 additional points.

1. **Client list / Organization Reference**

Supplier shares the examples of their experience in providing services similar to those included within the scope of this tender.

Examples provided must be for similar projects within a similar environment / context to that in which CUAMM operates, and within the last two (2) years (2022 and 2023). **Fill in the summary table below:**

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Client and contact | Type of Organization *(to be choose between: International-Local Ngo, UN agency, Bank, Hospital, Government Institution, etc)* | **To be attached the Reference Letter\*** | Project Description |
|  |  | Attached or not |  |
|  |  | Attached or not |  |
|  |  | Attached or not |  |
|  |  | Attached or not |  |
|  |  | Attached or not |  |
|  |  | Attached or not |  |
|  |  | Attached or not |  |
|  |  | Attached or not |  |
|  |  | Attached or not |  |
|  |  | Attached or not |  |

**\*Note: the Supplier must ensure that for any client references shared, the client is available to be contacted**

Max. 10 points ≥ 10 clients and each individual client 1 point

1. **Availability of Key roles and personnel**

The company has employees with verifiable capacity and experience whose duties include all the activities necessary for Quality Management and Good Distribution Practices (GDP) compliance, such as implementing and maintaining the quality system.

Please list names, job titles and contact details (e.g. Pharmacists, Pharmacy Technician, Procurement Manager etc,) as requested:

1. Indicate the total number of employees divided per area and attached the Organogram

|  |  |
| --- | --- |
| Total: |   |
| Management: |   |
| Sales: |   |
| Administrative:  |   |
| Others (specify) |   |

1. KEY STAFF: Pharmacist, Manager, CEO and other relevant positions to be detailed below. Please, attached the CV signed

|  |  |  |  |
| --- | --- | --- | --- |
| **Job Title** | **Role** | **Educational Certification** | **E-mail Address** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Max. 5 points ≥ 5 employees (with correct job title for the role covered) and each individual one 1 point. At least 2 of these 5 employees should have pharmacy qualification + Max. 5 points for well organized, clear and complete organogram

1. **Capacity to provide wide range of medical supplies**

The company can share evidence of experience in providing a wide range and categories of medical supplies.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Item Category** | **On what basis does your company select/qualify its manufacturers of multisource (generic) medicines?** | **Manufactures Company** **(name, address, web site, email)** | **Certifications held\*** | **Date of Last certification and certifying body\*\*** |
| Drugs & Pharmaceuticals |  |  |  |  |
| Medical consumables |  |  |  |  |
| Medical equipment & furniture  |  |  |  |  |
| Laboratory reagents & equipment |  |  |  |  |
| Medical Training supplies |  |  |  |  |

***\*****Specify the details of all certification held (eg. ISO9001, GMP certification, Certificate of Pharmaceutical Product According to WHO)*

***\*\*****Include date of last certification and details of the certifying body (Cuamm can make a spot check a request a copy). Details of any recent external corporate awards, including the awarding body, if relevant.*

*Max. 50 points for covering all, 10 points for each category*

1. **Fulfil Standard Medical Supply Storage requirements**

Does the company meet the minimum requirements for storage of items

|  |  |  |  |
| --- | --- | --- | --- |
| **Storage criteria** | **Feedback from the Supplier:** **Yes or Not (and comment)** | **Store Location** | **Means of verification provided?** |
| Stand-alone medical stores / warehouses with adequate space for storage of medical supplies - Well organized store / warehouse with and with free space for easy movement of persons and trolleys to access all supplies). It must be clean and hygienic (no rats). |  |  |  |
| All stores / warehouse meets the standard storage condition with the required standard of practice or guidelines – Temperature, Humidity, Light and free from water |  |  |  |
| All stores and warehouses are used only for storage of medical supplies. Not used for storage of other items |  |  |  |
| The company has at least 1 store or warehouse with cold chain system used for storage of pharmaceuticals that are temperature sensitive (cold chain items) |  |  |  |
| All stores and warehouse has a standard of practice in use for routine identification of short-dated and expired medical supplies. |  |  |  |
| The Vendor guarantee a separate area for the inflammable items |  |  |  |

Max. points are 30, each criteria should give a max of 5 points

1. **Capacity of delivery within the country**

|  |  |  |
| --- | --- | --- |
| **Can you deliver the items supplied in the sites listed below:** | YES / NO | Branch / local office and shop / to be specified the address (Yes / No + address) |
| JUBA |  |  |
| RUMBEK |  |  |
| YIROL |  |  |
| MUNDRI |  |  |
| NYAL or LEER |  |  |

Max. 15 points for covering all sites, 3 point for each site covered.

1. **Compliance with guidelines on good distribution practices (GDP) and Transport of Medical supplies**

|  |  |  |
| --- | --- | --- |
| **GDP & Transport criteria** | **Feedback from the Supplier:** **Yes or Not (and comment)** | **Means of verification provided?** |
| The company understand the commitment to the principles of Good Manufacturing Practices (GMP) and can provide Certificates of Analysis or Assessment or provide other type of quality control assurance documentation? |  |  |
| The company have an SOP and transport facilities in place to facilitate the transporting procured medical supplies and pharmaceuticals, including a system in place for the transport of cold chain items from the stores / warehouses to the recipients. |  |  |
| Products are delivered to the right recipients within a satisfactory time using appropriate proof of delivery documents |  |  |
| Delivery documents include batch number, expiry date and manufacturer name for pharmaceuticals and manufacturer name, model and serial number for equipment unit/set? |  |  |
| The company provide warranty on medical equipment they sale and provide post-sale maintenance services for equipment during warranty period. Provide names of organizations that have received “after sales maintenance” services in the last 1 year? |  |  |

Max. points are 20 and each individual store should give 4 points