**Annex III**

**Proposal Submission form**

**Dear Sir/Madam,**

Having examined the Solicitation Documents, the receipt of which is hereby duly acknowledged, I undersigned, offer to provide individual consulting services to UNDP Pakistan in accordance with the Price Schedule and TORs attached herewith and made part of this proposal.

I undertake, if my proposal is accepted, to commence and complete delivery of all services specified in the contract within the time frame stipulated.

I agree to abide by this proposal for a period of **90 day**s from the date fixed for opening of proposal in the invitation for proposal, and it shall remain binding upon us and may be accepted at any time before the expiration of that period.

I understand that you are not bound to accept any proposal you may receive.

Dated: this -------day of --------------2021

**Signature**

**Annex VI**

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| Icon  Description automatically generated**NT FOSULTANINDIVIDUAL CONTRACTORS**  **STATEMENT OF HEALTH – INDIVIDUAL CONTRACTORS**  Name of Consultant/Individual Contractor:  Last Name, First Name  **Statement of Good Health**  In accordance with the provisions of Clause 5 of the [General Terms & Conditions for Individual Contractors](https://intranet.undp.org/unit/oolts/oso/psu/_layouts/15/WopiFrame.aspx?sourcedoc=/unit/oolts/oso/psu/Support%20Documents%20on%20the%20IC%20Guidelines/UNDP%20General%20Conditions%20for%20Individual%20Contractors.pdf&action=default), I am submitting this statement to certify that I am in good health and take full responsibility for the accuracy of this Statement. I am aware that information pertaining to inoculation requirements in respect of official travel to countries can be referred to at <http://www.who.int/ith>.  I certify that my medical insurance coverage is valid for the period from       to (if applicable)  I certify that my medical insurance covers medical evacuations at Duty Station(s):       Duty Station(s) Rating:      “B through E”. Duty stations with “A” or “H” do not require medical evacuation coverage.  The name of my medical insurance carrier is:  Policy Number:  Telephone Number of Medical Insurance Carrier:  **A copy of proof of insurance MUST be attached to this form.** | | | |
|  |  |  |  |
| Signature of Consultant/Individual Contractor Date  This statement is only valid for Consultant/Individual Contractor Contract No. | | | |
|  |  |  |  |
| Signature of Officer Supervising the Contract Name | | | |
|  |  |  | |
| Business Unit | | | |