# UC HEALTH SYSTEM

# REQUEST FOR INFORMATION 1003

**Blood Products**

INTENT-TO-RESPOND NOTICE AND

REQUEST FOR CLARIFICATION(S)

This page must be completed signed below by an authorized company representative and returned to indicate acceptance of the terms and conditions of the UC Health System Request for Information and the company’s intent to submit a proposal.

Name of Company:

Company Representative/Title:

Phone Number including area Code:

Fax Number including area code:

Email Address:

Signature of authorized representative:

Return this transmittal form by the date indicated to:

RoseAnne Fischer, CLS, MM

UCI Medical Center, Pathology

Building 54, Room 4700

101 The City Dr.

Orange, CA 92868

Electronic scanned versions of this signed notification will be accepted by the due date at the following email address: RoseAnF@hs.uci.edu.

Respondents may use the MS-Word version of this form to send Request for Clarification questions by the due date.