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**ATTACHMENT D: RFQ CLIENT REFERENCE FORM/ RELEVANT PROJECT EXPERIENCE**

**Help Me Grow San Mateo County:**

**Child Health Care Provider Liaison**

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| **RFQ Respondent Name:** |
| **Relevant Experience/Project Name:** |
| **Client Organization Name (if applicable):** |
| **Location (City, State) :** |
| **Project Dates:** |
| **Project Cost:** |
| **Lead Contact Name, Title:** |
| **Email Address** |
| **Phone #:** |
| **Project Description:** |
| **Scope of Services Provided:** |
| **Completion Date:**      **Project Completed on Time:** **Yes** **No**  **Project Completed within Budget:** **Yes** **No If no, please explain:** |
| **List each member of your proposed team who worked on this project and their respective roles (if relevant):** |