Republic of the Philippines
**CIVIL AVIATION AUTHORITY OF THE PHILIPPINES**

# REQUEST FOR QUOTATION

The Civil Aviation Authority of the Philippines (CAAP-Main Office), through its Canvass and Contract Committee (CCC), will undertake a **Small Value Procurement** for the "Purchase of CAAP Form 548 application for Medical Certificate of Airmen" in accordance with Section 53.9 of the Implementing Rules and Regulations of Republic Act No. 9184.

| | | |
|---|---|---|
| RFQ No. | : | **C23-025-05** |
| Name of Project | : | **Purchase of CAAP Form 548 application for Medical Certificate of Airmen** |
| Approved Budget for for Contract | : | **₱99,990.00** |
| Terms | : | See the attached Annex "A" for Terms of Reference and corresponding Specifications |
| Location | : | Procurement Division, CAAP, MIA Road, Pasay City |
| Delivery Term | : | **One (1) month** from the receipt of Notice for Compliance<br>Note: Partial delivery is **not allowed** |
| Delivery Time | : | 8:00 AM – 4:00 PM (working days) |

Interested suppliers are required to submit their valid and current documents which must be properly fastened and sealed in an envelope:

1. Mayor's or Business Permit issued by the city or municipality where the principal place of business of the prospective bidder is located, or the equivalent document for Exclusive Economic Zones or Areas;
2. Income Business Tax Return for ABC's above ₱500,000.00;
3. PHILGEPS Certificate of Registration;
4. Tax Clearance;
5. Notarize Omnibus Sworn Statement (GPPB prescribed Form) for ABC's above ₱50,000.00; (Authorized representative much attach Special Power of Attorney (SPA) for Sole Proprietorship Certificate for Corporation)
6. Price quotation from (Annex "A") during submission of offer/Quotation and,
7. Brochure/Sample

The winning supplier shall – upon claiming of the Contract – present the original copy of the documents listed above for comparison, or submit a **Certified True Copy** of the original document which must be certified by the issuing government agency. However, the **original copy** of the Omnibus Sworn Statement, Price Quotation Form, and Brochure **must be included in the sealed bid.**

Price quotation/s must be valid for a period of one hundred twenty (120) calendar days from the date of submission.

Quotations exceeding the Approved Budget for the Contract shall be rejected.

Award of contract shall be made to the lowest quotation, which complies with the minimum description as stated above and other terms and conditions stated in the price quotation form. In case two or, more bidders are determined to have submitted the Lowest Calculated/Lowest Calculated and Responsive Quotation, CAAP-CCC shall adopt and employ "draw lots" as the tie breaking method to finally determine the single winning provider in accordance with GPPB Circular 06-2005.

The CAAP-TIAC shall have the right to inspect and/or test the goods to confirm their conformity to the technical specifications.

Any interlineations, erasures or overwriting shall be valid only if they are signed or initialed by the bidder or his/her duly authorized representative/s.

Liquidated damages equivalent to one tenth of one percent (0.1%) of the value of the goods not delivered within the prescribed delivery period shall be imposed per day of delay. CAAP shall rescind the contract once the cumulative amount of liquidated damaged reaches ten percent (10%) of the amount of the contract, without prejudice to other courses of action and remedies open to it.

**ATTY. JOHN BEAU B. MASIGLAT**
CCC-Chairperson

Republic of the Philippines
**CIVIL AVIATION AUTHORITY OF THE PHILIPPINES**

Annex "A"

## PRICE QUOTATION FORM

Date: ____________________

The Chairperson
Canvass and Contract Committee
Procurement Division, CAAP,
MIA Road, Pasay City

Sir:
After having carefully read and accepted the terms and conditions in the Request for Quotation, hereunder is our quotation/s for the item/s as follows:

| Description | | | | |
|---|---|---|---|---|
| **Purchase of CAAP Form 548 application for Medical Certificate of Airmen** | | | | |
| **Specification** | **QTY** | **Unit** | **Unit Price** | **Total Price** |
| **CAAP Form 548 (Application for Medical Certificate)**<br>• 8.5 x 13 long<br>• White<br>• 120gsm<br>• Submission of actual sample must be included during the submission of bid | **4,545** | **pcs** | | |
| **Delivery Location/s:**<br>CAAP Head Office Warehouse (Supply Division) | | | | |
| Inclusive of Delivery | | | | |
| Total (Inclusive of VAT) | | | | |

(Amount in Words) ______________________________________________________________

______________________________________________________________

The above-quoted prices are inclusive of all costs and applicable taxes.

Very truly yours,

______________________________
Name/Signature of Representative

______________________________
Position

______________________________
Name of Company

______________________________
Contact No.

______________________________
Email Address

Republic of the Philippines
**CIVIL AVIATION AUTHORITY OF THE PHILIPPINES**

## TERMS OF REFERENCE

| | | |
|---|---|---|
| NAME OF PROJECT | | Purchase Request of CAAP Form 548 application for Medical Certificate of Airmen. |
| APPROVED BUDGET | | Ninety Nine Thousand Nine Hundred Ninety Pesos (Php 99,990.00) |
| DELIVERY PERIOD | | One (1) month from the receipt of Notice for Compliance.<br><br>*Note: Partial Delivery is **not allowed*** |
| DELIVERY LOCATION | | CAAP Head Office Warehouse<br><br>*Note: Delivery must be made only from 8:00am- 4:00pm during regular work days.*<br><br>*A written Notice must be sent to the official e-mail address of the Procurement Division, and Supply Division at least seven (7) calendar days prior to the intended date of delivery.*<br><br>*A confirmation of availability of concerned office must be received by the supplier before proceeding with the delivery. None compliance may be ground for refusal of entry to the premises and receipt of delivery with no fault on the part of the Civil Aviation Authority of the Philippines.* |
| TERMS OF PAYMENT | | Payment upon full delivery and subject to usual government accounting rules and regulations. |
| TECHNICAL SPECIFICATIONS | 4,545 Pcs. | CAAP Form 548 ( Application for Medical Certificate)<br>• 8.5 x 13 long<br>• White<br>• 120gsm<br>• See Attached sample<br>• Submission of actual sample must be included during the submission of bid. |

Prepared by:

**JOHANNES CARMELA B. ALAGAO, RN**
Nurse II
OFSAM

Approved by;

**ROLLY T. BAYABAN, MD**
Chief, OFSAM
OFSAM

~~4".5 x 13"~~ ~~120gsm~~

# APPL[illegible]TION FOR MEDICAL CERTIFICATE

Control No.____________

**INSTRUCTIONS**

Print or type. Do not write in shaded areas. These are for CAAP use.
Submit original only to CAAP or a CAAP Authorized Person.
If additional space is required, use an attachment

**A. APPLICATION IS HEREBY MADE FOR ISSUANCE OF THE FOLLOWING AVIATION MEDICAL CERTIFICATE:**

1. ☐ CLASS 1 2. ☐ CLASS 2 3. ☐ CLASS 3

**B. AIRMAN PERSONAL INFORMATION:**

| 1. NAME(LAST-----------------------FIRST-------------------------MIDDLE) | 5. PERMANENT ADDRESS (Street or PO Box Number): |
|---|---|
| 2. TELEPHONE NUMBER: | |
| 3. FAX NUMBER: | |
| 4. EMAIL ADDRESS: | 6. CITY ISLAND/STATE/PROVINCE MAIL COUNTRY |

| 7. HEIGHT(m) | 8. WEIGHT (kg) | 9. HAIR | 10. EYES | 11. SEX | 12. DATE OF BIRTH / / DAY MONTH YEAR | 13. AGE | 14. FOR CAAP USE |
|---|---|---|---|---|---|---|---|

**C. PEL LICENSE AND MEDICAL INFORMATION:**

| 1. PEL LICENSE # | 2. TOTAL FLIGHT HOURS | 3. TOTAL LAST 6 MONTHS | 4. AVIATION EMPLOYER |
|---|---|---|---|

| 5. DATE LAST MEDICAL / / DAY MONTH YEAR | 6. HAS YOUR AVIATION MEDICAL CERTIFICATE EVER BEEN DENEID, SUSPENDED OR REVOKED? (a) ☐ **YES** (PROVIDE EXPLANATION) (b) ☐ **NO** If yes, give date: / / DAY MONTH YEAR | 8. FOR CAAP USE |
|---|---|---|
| 7. EXPLANATION FOR DENIAL, SUSPENSION OR REVOCATION | | |

**D. MEDICAL HISTORY:**

***HAVE YOU EVER IN YOUR LIFE BEEN DIAGNOSED WITH, HAD, OR DO YOU PRESENTLY HAVE ANY OF THE FOLLOWING?*** *Answer* ***"Yes"*** *or* ***"No"*** *for every condition listed below. In the* ***EXPLANATION*** *box below, you may note* ***"PREVIOUSLY REPORTED, NO CHANGE"*** *only if the explanation of the condition was reported on a previous application for an airman medical certificate and there has been no change in your condition* ***(See instruction for completion)***

| | YES | NO | CONDITION: | | YES | NO | CONDITION: |
|---|---|---|---|---|---|---|---|
| 1. | ☐ | ☐ | Frequent or severe headaches? | 13. | ☐ | ☐ | Neurological disorders, epilepsy, seizures, stroke, paralysis, etc. |
| 2. | ☐ | ☐ | Dizziness or fainting spell? | 14. | ☐ | ☐ | Mental disorder of any sort, depression, anxiety, etc |
| 3. | ☐ | ☐ | Unconsciousness for any reason? | 15. | ☐ | ☐ | Motion sickness requiring medication? |
| 4. | ☐ | ☐ | Eye or vision trouble except for glasses? | 16. | ☐ | ☐ | Medical discharge from any organization? |
| 5. | ☐ | ☐ | Hay fever or allergy? | 17. | ☐ | ☐ | Medical rejection by any organization? |
| 6. | ☐ | ☐ | Asthma or lung disease? | 18. | ☐ | ☐ | Rejection for life or medical insurance? |
| 7. | ☐ | ☐ | Heart or vascular trouble or HIV? | 19. | ☐ | ☐ | Admission to hospital? |
| 8. | ☐ | ☐ | High or low blood pressure? | 20. | ☐ | ☐ | Alcohol dependence or abuse? |
| 9. | ☐ | ☐ | Stomach, liver, or intestinal trouble? | 21. | ☐ | ☐ | Substance dependence, or substance abuse, or use of illegal substances in the last 2 years, or failed a drug test ever? |
| 10. | ☐ | ☐ | Kidney stone or blood in the urine? | | | | |
| 11. | ☐ | ☐ | Suicide attempt? | 22. | ☐ | ☐ | Other illness/disability or surgery? (attach report) |
| 12. | ☐ | ☐ | Diabetes or sugar in urine? | 23. | ☐ | ☐ | Near vision contact lenses? |

**24. EXPLANATIONS:** **25. FOR CAAP USE**

**E. VISITS TO HEALTH PROFESSIONAL WITHIN LAST 5 YEARS?** (a) ☐ **YES** *(Explain Below)* (b) ☐ **NO**

| ***Date*** | ***Name, Address, & Type of Health Professional Consulted*** | ***Reason*** |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**F. USE OF MEDICATION?** *(Daily or Regular Use: Non-Prescription or Prescription)* (a) ☐ **YES** *(List Below)* (b) ☐ **NO**

**G. CONVICTION AND/OR ADMINISTRATIVE HISTORY:**

1. ☐ YES (a) ☐ NO (b) History of (1) any conviction(s) involving driving while intoxicated by, while impaired by, or while under the influence of alcohol or a drug or (2) history of any conviction(s) or administrative action(s) involving an offense(s) which resulted in denial, suspension , cancellation or revocation of driving priviledge or which resulted in attendance at an educational or rehabilitation program?

2. ☐ YES (a) ☐ NO (b) History of nontraffic conviction(s)? (misdemeanors or felonies)

**3. FOR CAAP USE**

**H. CERTIFICATION -** ***I hereby represent that the information entered in this application is true and correct.***

| *A person shall not with intent to deceive, or make any false representation for the purpose of procuring for himself or any other person the grant, issue, renewal or variation of any such certificate.* | 1. DATE | 2. APPLICANT SIGNATURE |
|---|---|---|

## REPORT OF MEDICAL EXAMINATION

**I. GENERAL EXAMINATION:**

| 1. Height *(m)* | 2. Weight *(kg)* | 3. Body Mass Index | 4. Statement of Demonstrated Ability (a) ☐ YES (b) ☐ NO DEFECT NOTED? |
|---|---|---|---|

| | Normal | Abnormal | CONDITION: | | Normal | Abnormal | CONDITION: |
|---|---|---|---|---|---|---|---|
| 5. | ☐ | ☐ | Head, face, neck and scalp | 17. | ☐ | ☐ | Vascular System (pulse, amplitude, & character, arms, legs and other) |
| 6. | ☐ | ☐ | Nose | 18. | ☐ | ☐ | Abdomen and viscera (including hernia) |
| 7. | ☐ | ☐ | Sinuses | 19. | ☐ | ☐ | Anus (not including digital examination) |
| 8. | ☐ | ☐ | Mouth and Throat | 20. | ☐ | ☐ | Skin |
| 9. | ☐ | ☐ | Ears (general) | 21. | ☐ | ☐ | G.U. System (not including pelvic examination) |
| 10. | ☐ | ☐ | Ear Drums (perforation) | 22. | ☐ | ☐ | Upper and lower extremities (strength and range of motion) |
| 11. | ☐ | ☐ | Eyes (general) | 23. | ☐ | ☐ | Spine, other musculoskeletal |
| 12. | ☐ | ☐ | Ophthalmoscopic | 24. | ☐ | ☐ | Identifying body marks, scars, tattoos (size and location) |
| 13. | ☐ | ☐ | Pupils (equality and reaction) | 25. | ☐ | ☐ | Lymphatics |
| 14. | ☐ | ☐ | Ocular motility (associated parallel movement) | 26. | ☐ | ☐ | Neurologic (tendon reflexes, equilibrium, cranial nerves, etc.) |
| 15. | ☐ | ☐ | Lungs and Chest (not including breast exam) | 27. | ☐ | ☐ | Psychiatric (appearance, behavior, mood, communication & memory) |
| 16. | ☐ | ☐ | Heart (precordial activity rhythm, sounds & murmurs) | 28. | ☐ | ☐ | General Systemic |

**29.NOTES:** (Describe every abnormality in detail. Enter applicable item number before each comment. Use additional sheets if necessary and attach to this form.)

**J. HEARING:**

| 1. Conventional Voice Test (at 6 feet) | 2. Record Audiometric Speech Discrimination score Below | 3. Right Ear | | | | | | 4. Left Ear | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Audiometer | 500 | 1000 | 2000 | 3000 | 4000 | 500 | 1000 | 2000 | 3000 | 4000 |
| (a) ☐ Pass<br>(b) ☐ Fail | | Threshold in decibels | (a) | (b) | (c) | (d) | (e) | (a) | (b) | (c) | (d) | (e) |

**K. VISION:**

| 1. Distant Vision | 2. Near Vision | 3. Intermediate Vision | 4. Color Vision | 5. Visual Field |
|---|---|---|---|---|
| a. Right = 20/____ Corr. to 20/____ | a. Right = 20/____ Corr. to 20/____ | a. Right = 20/____ Corr. to 20/____ | Test Used ____________ | |
| b. Left = 20/____ Corr. to 20/____ | b. Left = 20/____ Corr. to 20/____ | b. Left = 20/____ Corr. to 20/____ | (a) ☐ Pass | |
| c. Both = 20/____ Corr. to 20/____ | c. Both = 20/____ Corr. to 20/____ | c. Both = 20/____ Corr. to 20/____ | (b) ☐ Fail | |

| **L. HETEROPHORIA** (in prism diopters): | ESO | EXO | R.H. | L.H. |
|---|---|---|---|---|

**M. CARDIOVASCULAR:**

1. Blood Pressure (a) Systolic: (b) Diastolic: 2. Pulse (Sitting): 3. ECG (date): 4. Chest Radiograph (date):

**N. URINALYSIS:**

1. ☐ Normal 2. ☐ Abnormal 3. Albumin (specify) ________________ 4. Sugar (specify) ____________________

**O. DRUG SCREENING:**

1. Methamphetamine a. ☐ NEGATIVE b. ☐ POSITIVE | 2. Cannabinoids a. ☐ NEGATIVE b. ☐ POSITIVE

**P. COMMENTS ON HISTORY AND FINDINGS:** AME shall comment **"YES"** answer in the Medical History section and for abnormal findings of the examination. (Attach all consultation reports, ECG's, X-rays, etc to this report before mailing.)

1. Significant Medical History? (a) ☐ YES (b) ☐ NO | 2. Abnormal Physical Findings? (a) ☐ YES (b) ☐ NO

**Q. MEDICAL EXAMINER'S ANALYSIS AND DECLARATION:**

1. ☐ ISSUANCE RECOMMENDED | 2. ☐ ISSUANCE NOT RECOMMENDED

**3. DISQUALIFYING DEFECTS:** (List by section letter and item number or enter the word " None")

***4. I hereby certify that i have personally reviewed the medical history and personally examined the applicant named on this medical examination report. This report with any attachments embodies my findings completely and correctly.***

| 5. Date of Examination<br>/ /<br>DAY MONTH YEAR | 6. AME SERIAL NUMBER | 8. AME PRINTED NAME | **10. FOR CAAP USE** |
|---|---|---|---|
| | 7. AME TELEPHONE NUMBER | 9. AME SIGNATURE | |