



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 "Supply and delivery of CAAP form 548 (Application for Medical Certificate)" in accordance with the Implementing Rules and Regulations of Republic Act No. 12009.

RFQ No.	:	<u>C25-012-05</u>
Name of Project	:	<u>Supply and delivery of CAAP form 548 (Application for Medical Certificate)</u>
Approved Budget for Contract	:	<u>₱300,000.00</u>
Terms	:	See the attached Annex "A" for Terms of Reference and corresponding Specifications
Location	:	Procurement Division, CAAP, MIA Road, Pasay City
Delivery Term	:	<u>One (1) Month</u> from the receipt of <u>Notice of Compliance</u> Partial delivery is <u>not allowed</u>
Delivery Time	:	8:00 AM – 4:00 PM Monday to Friday (Regular work days)
Delivery Location	:	<u>CAAP, Head Office Warehouse</u>

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 must attach Special Power of Attorney (SPA) for Sole Proprietorship Certificate for Corporation)
6. Price quotation from (**Annex "A"**) during submission of offer/Quotation

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.

The quotation shall be submitted in sealed envelope on or before the closing date of MAY 21 2025 at 10:00 AM, CAAP Procurement Division and addressed to:

ATTY. MARK NESTER T. MENDOZA
Chairperson, Canvass and Contract Committee
Gate 3 CAAP, Old MIA Road
Pasay City, Metro Manila

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.

Pasay City, May 13, 2025


ATTY. MARK NESTER T. MENDOZA
CCC Chairperson



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:

Supply and Delivery of CAAP Form 548 (Application for Medical Certificate)				
Technical Specifications	QTY	Unit	Unit Price	Total Price
CAAP Form 548 (Application for Medical Certificate) <ul style="list-style-type: none"> • 8.5 x 13 long • White • 80gsm. • See Attached sample • Submission of actual sample must be included during the submission of bid. 	20,000	Pcs.		

(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



TERMS OF REFERENCE

NAME OF PROJECT		Supply and Delivery of CAAP form 548 (Application for Medical Certificate)
APPROVED BUDGET		Three hundred thousand pesos only (Php 300,000.00)
DELIVERY PERIOD		One (1) month from the receipt of Notice for Compliance. <i>Note: Partial Delivery is not allowed</i>
DELIVERY LOCATION		CAAP Head Office Warehouse <i>Note: Delivery must be made only from 8:00am- 4:00pm during regular work days.</i> <i>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.</i> <i>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.</i>
TERMS OF PAYMENT		Payment upon full delivery and subject to usual government accounting rules and regulations.
TECHNICAL SPECIFICATIONS	20,000 Pcs.	CAAP Form 548 (Application for Medical Certificate) <ul style="list-style-type: none">• 8.5 x 13 long• White• 80gsm• See Attached sample• Submission of actual sample must be included during the submission of bid.

Prepared by:


JOHANNES CARMELA B. ALAGAO, RN
Nurse III

Approved by;


ROLLY T BAYABAN, MD
Chief, OFSAM



APPLICATION FOR AVIATION MEDICAL CERTIFICATE

INSTRUCTIONS: Print or type in blue or black ink. Submit original only to Aeromedical Staff.

When downloading the form, use legal size paper (8.5x14 inches) and should be printed double-sided (back-to-back).

Do not leave any blanks, write N/A if not applicable. If additional space is required, use an attachment.

CONTROL NO.:

A. APPLICATION IS HEREBY MADE FOR ISSUANCE OF THE FOLLOWING AVIATION MEDICAL CERTIFICATE:						LICENSE HELD:			
1. <input type="checkbox"/> CLASS 1		2. <input type="checkbox"/> CLASS 2		3. <input type="checkbox"/> CLASS 3					
B. AIRMAN PERSONAL INFORMATION:									
1. NAME (LAST-----FIRST-----MIDDLE)				4. PERMANENT ADDRESS (House No., Street, City, Province, Country, Zip Code)					
2. CONTACT NUMBER:									
3. EMAIL ADDRESS:									
5. DATE OF BIRTH / / DAY MONTH YEAR		6. Age	7. Sex		8. Citizenship	9. Hair Color	10. Eye Color		
C. PEL LICENSE AND MEDICAL INFORMATION:									
1. PEL LICENSE #		2. TOTAL FLIGHT HOURS		3. TOTAL LAST 6 MONTHS		4. AVIATION EMPLOYER/SCHOOL			
5. DATE LAST MEDICAL / / DAY MONTH YEAR		6. HAS YOUR AVIATION MEDICAL CERTIFICATE EVER BEEN DENIED, SUSPENDED OR REVOKED? (a) <input type="checkbox"/> YES (PROVIDE EXPLANATION) (b) <input type="checkbox"/> NO If yes, give date: / / DAY MONTH YEAR							
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, indicate what and when were you diagnosed and management or treatment if any.									
YES	NO	CONDITION:			YES	NO	CONDITION:		
1. <input type="checkbox"/>	<input type="checkbox"/>	Frequent or severe headaches?			13. <input type="checkbox"/>	<input type="checkbox"/>	Neurologic disorders, epilepsy, seizures, stroke, paralysis, etc.		
2. <input type="checkbox"/>	<input type="checkbox"/>	Dizziness or fainting spell?			14. <input type="checkbox"/>	<input type="checkbox"/>	Mental condition of any sort, depression, anxiety, etc.		
3. <input type="checkbox"/>	<input type="checkbox"/>	Unconsciousness for any reason?			15. <input type="checkbox"/>	<input type="checkbox"/>	Motion sickness requiring medication?		
4. <input type="checkbox"/>	<input type="checkbox"/>	Eye or vision trouble except for glasses?			16. <input type="checkbox"/>	<input type="checkbox"/>	Medical discharge from any organization?		
5. <input type="checkbox"/>	<input type="checkbox"/>	Hay fever or allergy?			17. <input type="checkbox"/>	<input type="checkbox"/>	Medical rejection from any organization?		
6. <input type="checkbox"/>	<input type="checkbox"/>	Asthma or lung disease?			18. <input type="checkbox"/>	<input type="checkbox"/>	Rejection for life or medical insurance?		
7. <input type="checkbox"/>	<input type="checkbox"/>	Heart or vascular trouble or HIV?			19. <input type="checkbox"/>	<input type="checkbox"/>	Admission to hospital?		
8. <input type="checkbox"/>	<input type="checkbox"/>	High or low blood pressure?			20. <input type="checkbox"/>	<input type="checkbox"/>	Alcohol dependence or abuse?		
9. <input type="checkbox"/>	<input type="checkbox"/>	Stomach, liver, or intestinal trouble?			21. <input type="checkbox"/>	<input type="checkbox"/>	Substance dependence, substance abuse, or use of illegal substance in the last 2 years, or failed a drug test ever?		
10. <input type="checkbox"/>	<input type="checkbox"/>	Kidney stone or blood in the urine?			22. <input type="checkbox"/>	<input type="checkbox"/>	Other illness/ disability or surgery? (attach report)		
11. <input type="checkbox"/>	<input type="checkbox"/>	Suicide attempt?			23. <input type="checkbox"/>	<input type="checkbox"/>	Near vision contact lenses?		
12. <input type="checkbox"/>	<input type="checkbox"/>	Diabetes or sugar in urine?							
24. EXPLANATIONS:									
E. VISITS TO HEALTH PROFESSIONAL WITHIN LAST 3 YEARS? (a) <input type="checkbox"/> YES (Explain Below) (b) <input type="checkbox"/> NO									
DATE		Name, Address, Type of Health Professional Consulted				Reason			
F. USE OF MEDICATION? (Daily or Regular Use: Non-Prescription or Prescription) (a) <input type="checkbox"/> YES (List Below) (b) <input type="checkbox"/> NO									
G. CONVICTION AND/OR ADMINISTRATIVE HISTORY:									
1. <input type="checkbox"/> YES (a)		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 privilege or which resulted in attendance at an educational or rehabilitation program?				2. <input type="checkbox"/> YES (a)		History of nontraffic conviction(s)? (misdemeanors or felonies)	
<input type="checkbox"/> NO (b)						<input type="checkbox"/> NO (b)			
H. CERTIFICATION AND CONSENT – I hereby represent that the information entered in this application is true and correct.									
1. 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.									
2. In compliance with the Data Privacy Act of 2012 and to ensure a safe and transparent usage of your personal information, the data you will submit will be used for the purpose of aeromedical application and assessment. Your personal information or data will be retained and disposed according to the existing laws and regulations of the National Archives of the Philippines. By signing below you agreed, understood and gave your consent.									
_____ APPLICANT'S SIGNATURE OVER PRINTED NAME				_____ DATE					

