

## STATEMENT OF AGREEMENT

---

*I certify that:*

- Medical providers in our employ:
  - Are not currently excluded, suspended or otherwise barred from participation in the Medicare or Medicaid programs or any other federal or federally assisted program;
  - Have licenses that are current and active, and are not currently revoked, suspended or sanctioned by any State licensing authority for any reason;
  - Have not surrendered his/her license pending disciplinary procedures involving professional misconduct;
  - Will immediately notify the DDDS if there is any pending disciplinary action against my license. Failure to do so could result in termination of an agreement to perform services and/or legal action;
  - Understand that a credentials check will be done initially and periodically by the Social Security Administration (SSA)/Washington Division of Disability Determination Services (DDDS);
  - Have been provided with an overview of SSA's disability programs and regulations, including the need to include a medical source statement about the DDDS Client's ability to do work related activities in the consultative examination report;
  - Understand all requests for copies of reports, including subpoenas, be referred to the DDDS Professional Department immediately.
  - Understand the basic requirement to maintain the confidentiality of medical records stems from Section 1106 of the Social Security Act, and it's implementing Regulations No. 1 (42 U.S.C. 1306: 20 CFR 401). Section 1106 prohibits disclosure of information obtained in the administration of Social Security program except as prescribed by regulation, and makes unauthorized disclosure a crime. These prohibitions extend to any background data furnished to you in conjunction with performing a consultative examination for our agency, including any copies of reports retained by you. Unauthorized disclosure of such records is prohibited;
- All support staff used in the performance of consultative examinations (CEs) meet the appropriate licensing and certification requirements of the state; and are not currently excluded, suspended or otherwise barred from participation in the Medicare or Medicaid programs or any other federal or federally assisted programs;
- I understand the recommended scheduling interval requirements for CEs performed for the Washington DDDS is at least 30 minutes, or in accordance with accepted medical practice;
- I provide equal access and quality of service to people with disabilities, from diverse ethnic backgrounds, and to members of sexual minority groups; and
- I understand I can voluntarily terminate panel membership at anytime, and conversely that involuntary termination is at the discretion of the Professional Relations staff.

**I certify** that, to the best of my knowledge and belief, all the information on this form is correct. I understand that I will not be considered for an agreement to provide services if I am unable to certify to the above and that false certification will be grounds for termination of any resulting agreement to provide services.

SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_