

STATEMENT OF AGREEMENT

I certify that:

- I am not currently revoked or suspended by any state licensing agency;
- My license is current and active. I am not currently excluded, suspended or otherwise barred from participation in Medicare and Medicaid programs or any other federal or federally assisted programs; and, I understand a credentials check will be performed initially and periodically by the Social Security Administration (SSA)/Washington Division of Disability Determination Services (DDDS);
- I do not have a current or pending Federal SSA Contract;
- I have possessed two (2) years of clinical experience as a psychologist in health service, at least one (1) year of which is post-Master's Degree;
- I have a minimum of five (5) years of current experience with psychological consultation with the DDDS;
- I have the ability to work a reliable and consistent schedule with the majority of the work hours during DDDS business hours (Monday – Friday, 6:00 AM – 8:00 PM) and provide consultation and questions during core business hours (Monday – Friday, 6:00 AM – 6:30 PM). I understand exceptions, in rare and exceptional circumstances, can be made at the discretion of DDDS Management;
- I am to serve as a consultant to the Division Director to ensure psychological medical reviews are conducted consistently with SSA POMS and current medical practices;
- I am able to participate in mandatory quarterly MC Meetings during the months of February, May, August, and November (unless excused in advance);
- I am to attend training sessions as required;
- I am to accurately record all hours worked by reporting proper Timekeeper activity codes;
- I understand I am expected to complete a minimum of one (1) case per hour for case review, conclusions, and signature;
- I am not to directly contact medical providers outside my scope of work which includes making recommendations to Adjudicative Staff to contact medical providers to perform consultative examinations, obtaining medical evidence, and corresponding with medical providers to conduct/schedule consultative examinations, etc.;
- I am not to provide comments or references that are unprofessional in case files, emails, letters, or any correspondences;
- I am to treat DDDS staff with courtesy and respect; and
- I am not to use social media (i.e. Facebook, Google, Instagram, Twitter, etc.) for gain of DDDS Client information; and understand this applies to using a computer or personal device.

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: _____