STATEMENT OF AGREEMENT

(do not initial, comment, or mark on form)

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 programs;
    - Have licenses that are current and active and have not been revoked or suspended by any State licensing authority for reasons bearing on professional competence, professional conduct, or financial integrity;
    - Have not surrendered his/her license while awaiting final determination on formal disciplinary proceedings involving professional misconduct;
    - Will immediately notify the DDDS if there is any pending disciplinary action against his/her 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 made upon his/her initial agreement to perform services and periodically thereafter by the DDDS;
    - 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 who participate in the conduct of consultative examinations, and any third parties who conduct other studies purchased by the Washington State Division of Disability Determination Services (DDDS), meet all appropriate licensing or certification requirements of the State, as required by the Social Security Administration's (SSA) regulations (20 C.F.R. 404.1519g, and 416.919g); and, not currently excluded, suspended, or otherwise barred from participation in the Medicare or Medicaid programs, or any other federal or federally assisted programs, as required by SSA's regulations (20 CFR 404.1503a, and 416.903a);
- I understand the recommended scheduling interval requirements for CEs performed for the Washington DDDS is in accordance with the Scheduling section of the Contract; 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: _____

(wet ink signature required)