Provider Attestation Form

As a Children's Medical Services Provider, I attest to the following:

I fully understand that any significant misstatement or omission from this application constitutes cause for denial of approval or cause for summary termination from participating as a provider with Children's Medical Services (CMS). All information submitted by me in this application is true to the best of my knowledge and belief.

In addition, I attest that I have disclosed and submitted official documentation related to the following when applicable:

- Professional Liability Claims History;
- Information on license revocation, suspension, voluntary relinquishment, licensure probationary status, or other licensure conditions or limitations;
- Complaints or adverse action reports filed against my with a local, state or national professional society or licensure board;
- Refusal or cancellation of professional liability coverage;
- Denial, suspension, limitation, termination, or nonrenewal of professional privileges at any hospital, national professional society or licensure board;
- Refusal or cancellation of professional liability coverage;
- Denial, suspension, limitation, termination, or nonrenewal of professional privileges at any hospital, health plan, medical group or other health care entity;
- DEA and state license action;
- Disclosure of any Medicare/Medicaid sanctions;
- Convictions of a criminal offense (other than minor traffic violations); and,
- Current physical, mental health, or chemical dependency issues that would interfere with my ability to provide high quality patient care and professional services

I have read the CMS Provider Handbook and hereby voluntarily agree to provide services to CMS patients in accordance with the standards presented within that document.

I hereby apply to participate in CMS and authorize CMS, through its agents and employees, to contact any and all agencies, institutions, and persons listed herein for the purpose of obtaining background data, information, and records relevant to my application. I further authorize, and agree to hold harmless, all agencies, institutions, and person listed herein to release to CMS, upon request, background data, information, and records relevant to my application, including records that might be otherwise confidential or exempt from the public records law of the State of Florida. Confidential or exempt records released to CMS pursuant to this authorization shall otherwise retain their confidential or exempt status. A copy of this authorization to release information shall be deemed as valid as the original.

______________________________ Signature of Applicant

______________________________ Date

______________________________ Print name of Applicant