Medicare, Medicaid Patient and Program Protection Act Affidavit

I HEREBY CERTIFY THAT

I am the _____ and the duly
(Title)
authorized representative of the firm of _____

whose address is _____

_____,and that I possess the legal authority to make this affidavit on behalf of myself and the firm for which I am acting.

In reference to the Medicare and Medicaid Patient and Program Protection Act of 1987, Public Law 100-93, at 42USC s1397(d)(a)(9), neither I, nor to the best of my knowledge, the above firm, nor any of its officers, directors, or partners, have been convicted of or have pleaded nolo contendere to Medicare fraud, or Medicaid fraud, or patient abuse, or have been excluded by the Secretary of Health and Human Services from participation in the Medicare Program or excluded from any state health program.

I do solemnly declare and affirm under the penalties of perjury that the contents of this affidavit are true and correct.

_____ _____
Witness Signature

_____ _____
Date Printed or Typed Name

MMP 3/99