

**SAMPLE FORM OF ELIGIBILITY ATTESTATION FOR PRACTITIONERS**

By executing this Attestation, I acknowledge that I am a Member or a Physician Equity Owner of \_\_\_\_\_ (“Company”) and I hereby represent, warrant and agree as follows:

**INSTRUCTIONS**

Please answer all questions and fill in all blanks. Use “N/A” if an item is not applicable. Capitalized terms used in this Attestation but not defined in this Attestation have the same meanings as in the Company Agreement.

**ATTESTATION.**

1. I am a resident of the State of Texas. \_\_\_\_\_ (True) \_\_\_\_\_ (False)
2. I currently hold the following degree(s) relating to the performance of health care services. \_\_\_\_\_ (M.D.) \_\_\_\_\_ (D.O.) \_\_\_\_\_ (D.D.S.) \_\_\_\_\_ (Other).
3. I currently hold an unrestricted license to practice medicine in my health care specialty in Texas and there is no pending investigation of my license in any state: \_\_\_\_ (True) \_\_\_\_ (False).
4. I am an active member of the medical staff with current privileges to provide services in the Hospital. \_\_\_\_\_ (True) \_\_\_\_\_ (False).
5. I have a reasonable expectation of providing medical services at the Hospital in the 12 month period following the date of this Attestation \_\_\_\_ (True) \_\_\_\_ (False).
6. During the preceding 12 month period, I informed patients whom I referred to the Hospital of my ownership interest in the Hospital and I will continue to do so. A copy of the form of notice I currently use to inform patients of my ownership interest is provided with my response. \_\_\_\_ (True) \_\_\_\_ (False).
7. Neither the Company, the Manager, nor any Member loaned funds or guaranteed a loan to me in connection with my purchase of my ownership interest. \_\_\_\_ (True) \_\_\_\_ (False).
8. I:
  - a. have not been convicted of a criminal offense under any provision of the federal Social Security Act \_\_\_\_\_ (True) \_\_\_\_\_ (False).
  - b. have not had any civil monetary penalties, assessments or sanctions imposed against me under any provision of the Social Security Act or in relation to a violation of federal or state health care laws or regulations, including those

governing false claims and kickbacks, and no action relating to such a finding is pending. \_\_\_\_\_ (True) \_\_\_\_\_ (False).

- c. am not, and have not been, excluded, suspended or debarred at any time from participation in Medicare, Medicaid or any other federal or state health care program, or debarred from any federal procurement or non-procurement program, and no such action is pending. \_\_\_\_ (True) \_\_\_\_\_ (False).
  - d. have not entered into a Corporate Integrity Agreement or Certification of Compliance Agreement, or any other similar arrangement, with the federal government. \_\_\_\_\_ (True) \_\_\_\_\_ (False).
  - e. have not been finally adjudicated and found guilty, or entered a plea of guilty or nolo contendere, in a criminal prosecution under the laws of any state or the United States, for any offense reasonably related to the provision of healthcare items or services or for any offense an essential element of which is fraud, dishonesty or an act of violence, or for any offense involving moral turpitude, whether or not sentence was imposed and no such action is pending. \_\_\_\_ (True) \_\_\_\_\_ (False).
9. I have not been divorced or made any transfer, pledge, assignment or other disposition of all or any part of my ownership interest since my last Attestation, or I have given the Company written notice of such event and sought prior approval. \_\_\_\_\_ (True) \_\_\_\_\_ (False).
10. I agree to treat patients receiving medical benefits or assistance under governmental health care programs in a non-discriminatory manner. \_\_\_\_\_ (True) \_\_\_\_\_ (False).

CERTIFIED AND EXECUTED on the date set forth below my signature.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Name)

Date Signed: \_\_\_\_\_