PROVIDER ENROLLMENT SERVICES
ENROLLMENT/PAYOR REQUIRED FORMS CHECKLIST

Provider Name

Physicians are required to complete the Provider Enrollment Database form and sign the additional forms listed as part of the enrollment process:

- [ ] Provider Enrollment Database Form
- [ ] Provider Practice Location Information Form
- [ ] CAQH Attestation
- [ ] Blue Cross Blue Shield Practitioner Application Release Form
- [ ] Emblem/HIP Network Services IPA Participating Practitioner Agreement
- [ ] Emblem/HIP HMO Certification Regarding Lobbying
- [ ] Emblem/GHI PPO Participating Practitioner Agreement
- [ ] Emblem/GHI Provider Certification Regarding Lobbying
- [ ] ADA Attestation Form

Additional forms will be generated from Provider Enrollment:

- Medicare Enrollment and Re-Assignment Forms
- Medicaid Enrollment and Certification Statement Forms

Thank you,

Albert Guidice
Provider Enrollment Manager

X
Person Completing Check List

X
Initials/Date
Provider First Name: ___________________ Last Name: ___________________
Primary Practice Address: ___________________________ UPS □ UHB □ BOTH □
City/State/Zip: ____________________________________

Appointment Phone Number: (____) _________________
Office Fax Number: (____) _________________ Contact Person: ____________________________
Office Hours:
Monday: _________ Tuesday: _________ Wednesday: _______
Thursday: _______ Friday: _______ Saturday: _______ Sunday: _______

Secondary Practice Address: ___________________________ UPS □ UHB □ BOTH □
City/State/Zip: ____________________________________

Appointment Phone Number: (____) _________________
Office Fax Number: (____) _________________ Contact Person: ____________________________
Office Hours:
Monday: _________ Tuesday: _________ Wednesday: _______
Thursday: _______ Friday: _______ Saturday: _______ Sunday: _______
Standard Authorization, Attestation and Release

[Not for Use for Employment Purposes]

I understand and agree that, as part of the credentialing application process for participation, membership and/or clinical privileges (herein referred to as “Participation”) at or under the stand and each healthcare organization on the “List of Authorized Organizations” (individually referred to as the “Entity”), and of the Entity’s affiliated entities, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training, work experience, clinical competence, health status, character, ethics, and any other criteria used by the Entity for determining initial and ongoing eligibility for Participation. Each Entity and its representatives, employees, and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law.

I acknowledge that each Entity has its own criteria for acceptance, and I may be rejected or accepted by each independently. I further acknowledge and understand that my cooperation in obtaining and submitting all required information may not guarantee that any Entity will grant me clinical privileges or contract with me as a provider of services. I further understand that my application for or participation in the Entity is not an application for employment with the Entity and that acceptance of my application by the Entity will not result in my employment by the Entity.

Authorization of Investigation Concerning Application for Participation. I authorize the following individuals including, without limitation, the Entity, its representatives, employees, and/or designated agent(s); the Entity’s affiliated entities and their representatives, employees, and/or designated agents; and the Entity’s designated professional credentialing organization to conduct any investigations, including, without limitation, the collection of any and all records, documents, and data concerning my application for Participation. I agree to allow the Entity and/or its Agent(s) to inspect and copy all records and documents relating to such an investigation.

Authorization of Third-Party Sources to Release Information Concerning Application for Participation. I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Quality and Protection Data Bank, to release to the Entity and/or its Agent(s), information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, habits, behavior, or any other matter reasonably having a bearing on my qualifications for Participation or, with, the Entity, I authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

Authorization of Release and Exchange of Disciplinary Information. I hereby further authorize any third party at which I currently have Participation or Participation and/or each third party’s agents to retain “Disciplinary information,” as defined below, to the Entity and/or its Agent(s). I hereby further authorize the Agent(s) to release Disciplinary information about any disciplinary action taken against me to the participating Entities at which I have Participation, and as may be otherwise required by law. As used herein, “Disciplinary Information” means information concerning (i) any action taken by any health care organization, their administrators, or their medical or other committees to revoke, deny, suspend, restrict, or condition my Participation or impose a corrective action plan; (ii) any other disciplinary action involving me, including, but not limited to, discipline in the employment context, or (iii) my designation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges, but after I have knowledge that such formal charges were being (or are being) contemplated and/or were (or are) in preparation.

Release from Liability. I release from all liability and hold harmless any Entity, its Agent(s), and any other third party for their acts performed in good faith and without malice under such acts are due to the good neighbor or lawful misconduct of the Entity, its Agent(s), or any other third party in connection with the gathering, receipt, and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. I further agree not to sue any Entity, any Agent(s), or any other third party for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such Entity, Agent(s), or third party in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities. In this Authorization, Attestation and Release, all references to the Entity, its Agent(s), and/or other third party include their respective employees, directors, officers, advisors, counsel, and agents. The Entity and/or its affiliated agents or agents retain the right to allow access to the application information for purposes of a credentialing audit to customs and/or their auditors to the extent required in connection with an audit of the credentialing processes provided that the customer and/or their auditor executes an appropriate confidentiality agreement. I understand and agree that this Authorization, Attestation, and Release is irrevocable for any period during which I am an applicant or Participating in the Entity, a member of an Entity’s medical or health care staff, or a participating provider of an Entity. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. I understand that my failure to promptly provide another consent may be grounds for termination or discipline by the Entity in accordance with the applicable bylaws, rules, and regulations, and agreements or terms of the Entity, or grounds for my termination of Participation at or with the Entity. I agree that information obtained in accordance with the provisions of this Authorization, Attestation, and Release will not and will not be a violation of my privacy.

I certify that all information provided by me in my application is current, true, correct, accurate and complete to the best of my knowledge and belief, and is furnished in good faith. I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information (including any changes in characteristics to licensure, DEA, insurance, malpractice claims, NPI/DNPI/DOS reports, discipline, criminal convictions, etc.) I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to the determination of Participation by the Entity, and must be submitted online or in writing, and must be dated and signed by me (may be a written or electronic signature). I acknowledge that the Entity will not process an application until they deem it to be a complete application and that I am responsible to provide a complete application and to produce adequate and timely information for resolving questions that arise in the application process. I understand and agree that any material misstatement or omission in the application may result in the revocation of participation, and that I authorize the Entity to cancel the application for any reason that it may determine in its discretion, and to revoke the participation for any other reason that it may determine in its discretion.

This document may be disclosed to the Entity and/or its Agent(s). I further acknowledge that I have read and understand the foregoing Authorization, Attestation, and Release and that I have access to the bylaws of applicable medical staff organizations and agree to abide by these bylaws, rules and regulations. I understand and agree that a facsimile or photocopy of this Authorization, Attestation, and Release shall be as effective as the original.

[Signature]

[Name] (Print)

[Date Signed]
EMPIRE BLUECROSS BLUESHIELD
PRACTITIONER APPLICATION RELEASE FORM

**PRACTITIONER INFORMATION**

<table>
<thead>
<tr>
<th>Provider Number:</th>
<th>Billing NPI Number:</th>
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<tr>
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<th>First Name:</th>
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<thead>
<tr>
<th>Date of Birth:</th>
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<tr>
<th>Sex: Male</th>
<th>Female</th>
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<tr>
<th>Languages Spoken:</th>
<th>E-mail Address:</th>
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<table>
<thead>
<tr>
<th>Primary Office Address:</th>
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<table>
<thead>
<tr>
<th>City:</th>
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<tr>
<th>Telephone #:</th>
<th>Fax #:</th>
<th>Contact Name:</th>
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**SAMSA Certified Medication Assisted Therapy (MAT) Provider**

<table>
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<tr>
<th>Yes</th>
<th>No</th>
<th>NA</th>
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**OFFICE HOURS**

Hours Of Availability To See Patients In Primary Office (PCP & OB/GYN Must Have A Minimum Of 16 Office Hours/Week)

<table>
<thead>
<tr>
<th>Monday</th>
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I have NO OFFICE HOURS AND RENDER SERVICES ONLY WITHIN AN INPATIENT SETTING (HOSPITALIST) ☐

I AM A CERTIFIED NURSE MIDWIFE AND HAVE INCLUDED DOCUMENTS VERIFYING MY COLLABORATING PHYSICIAN ☐

**HOSPITAL AFFILIATIONS**

List all - Use Separate Sheet if Necessary

1. 

2. 

**SPECIALTY**

Applying As: (Please Check) Primary Care Provider / OB/GYN ☐ Referral Specialist ☐ Both ☐

<table>
<thead>
<tr>
<th>Specialty:</th>
<th>Board Eligible?: Yes</th>
<th>No</th>
<th>Date:</th>
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<tr>
<th>Sub-Specialty:</th>
<th>Board Eligible?: Yes</th>
<th>No</th>
<th>Date:</th>
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**PAR BACKUPS**

List all - Use Separate Sheet if Necessary

<table>
<thead>
<tr>
<th>Name</th>
<th>Provider ID</th>
<th>Address</th>
<th>Phone</th>
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I hereby certify that the all information indicated herein is true, accurate and complete. Furthermore I understand that the knowing submission of any incorrect information may result in the possible disqualification of my application, termination of my agreement with Empire BlueCross BlueShield and reporting to any applicable State, Federal or Regulatory agency.

Practitioner Signature: Date: 

**Network Use Only**

<table>
<thead>
<tr>
<th>Network Management Consultant:</th>
<th>Internal Flags:</th>
<th>Date Empire Received:</th>
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AGREEMENT BETWEEN
HIP NETWORK SERVICES IPA, INC.
AND PARTICIPATING PRACTITIONER

HIP Network Services IPA ("HNSIPA"), is pleased to contract with the undersigned Practitioner for the provision of Covered Services to Members. Practitioner and HNSIPA are entering into this Agreement in order for Practitioner to provide services as a Participating Provider to Members according to the terms and conditions of this Agreement, the Plan's Administrative Guidelines including but not limited to the Plan's Provider Manual and each Member's Benefit Program. HNSIPA and Practitioner agree to abide by the Quality Improvement, Utilization Management and other applicable rules, policies and procedures of the Plan with whom HNSIPA contracts to provide services. This Agreement (consisting collectively of this page, the body of the agreement that follows and the Prevailing Plan Fee Schedule annexed hereto as Attachment A, plus all other exhibits and other attachments), as well as the Administrative Guidelines and Provider Manual, as amended from time to time and published on the Plan's website, constitutes the complete and sole contract between the parties regarding the subject matter of the Agreement and, except as otherwise provided herein, supersedes any and all prior or contemporaneous oral or written communications not expressly included in the Agreement. Subject to any necessary regulatory approvals, the effective date of this Agreement is __________ (“Start Date”), contingent upon any necessary Credentialing Committee approval.

If Practitioner is a professional corporation this Agreement shall apply to each member of such corporation as if each is a party to this Agreement. In consideration of the mutual covenants and promises stated herein and other good and valuable consideration, and intending to be legally bound hereby, HNSIPA and Practitioner enter into this Agreement to be effective as of the Start Date.

Practitioner

By (Signature)

Name (Print) ______________________________ Date ________________

Organization University Physicians of Brooklyn, Inc.

Address 450 Clarkson Ave.

Brooklyn, NY 11203

Telephone ______________________________ License #: ______________________________

Email ______________________________ NPI#: ______________________________

HIP Network Services IPA, Inc.

Date: ________________

Name: ______________________________

Signature: ______________________________
CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge, that:

1. No Federal appropriated funds have been paid or will be paid to any person by or on behalf of the Practitioner for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of a Member of Congress in connection with the award of any Federal loan, the entering into any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress in connection with the award of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into any cooperative agreement, or the extension, continuation, renewal, amendment or modification of this Federal contract, grant, loan, or cooperative agreement, and the Agreement exceeds $100,000, Practitioner shall complete and submit Standard Form-LLL "Disclosure Form to Reporting Lobby," in accordance with its instructions.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into submission of this certification is a prerequisite for making or entering into this transaction pursuant to U.S.C. Section 1352. The failure to file the required certification shall subject the violator to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Practitioner

By (Signature)

Name (Print) Date

Organization University Physicians of Brooklyn, Inc.

Address 450 Clarkson Ave.

Brooklyn, NY 11203

Telephone State License #: NPI#

Email
EMBLEMHEALTH PARTICIPATING PRACTITIONER AGREEMENT

Group Health Incorporated and the other EmblemHealth companies listed on the attached addendum, if any, and their affiliated and successor companies (referred to hereinafter as "EmblemHealth"), is pleased to contract with the undersigned Practitioner ("Practitioner") for the provision of Covered Services to Members. Practitioner shall render Covered Services to Members according to the terms and conditions of this Agreement, EmblemHealth’s Administrative Guidelines, Provider Manual and policies and procedures, and each Member’s Benefit Program listed on Attachment B. Practitioner agrees to abide by the Quality Improvement, Utilization Management, Claims Submission and other applicable rules, policies and procedures of EmblemHealth. This Agreement (consisting collectively of this page, the body of the agreement that follows, the Prevailing Plan Fee Schedule and terms annexed hereto as Attachment A, plus the Addendums and Attachments which are incorporated herein and the Administrative Guidelines, as they may be amended from time to time and published on the EmblemHealth website, constitutes the complete and sole contract between the parties regarding the subject matter of the Agreement and, except as otherwise provided herein, supersedes any and all prior or contemporaneous oral or written communications not expressly included in the Agreement. The Start Date of this Agreement shall be forty-five (45) days after counter execution of this Agreement by EmblemHealth ___________ ("Start Date"). If Practitioner is a professional corporation this Agreement shall apply to each Member of such corporation as if each is a party to this Agreement. In consideration of the mutual covenants and promises stated herein and other good and valuable consideration and intending to be legally bound hereby, EmblemHealth and Practitioner enter into this Agreement to be effective as of the Start Date.

<table>
<thead>
<tr>
<th>Practitioner</th>
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<tbody>
<tr>
<td>By (Signature)</td>
</tr>
<tr>
<td>Name (Print)</td>
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<tr>
<td>Organization</td>
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<tr>
<td>Address</td>
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<tr>
<td>Telephone</td>
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<tr>
<td>Email</td>
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<tr>
<td>NPI#</td>
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<tr>
<th>Group Health Incorporated</th>
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<tbody>
<tr>
<td>Date:</td>
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<tr>
<td>Name:</td>
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<td>Signature:</td>
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EH-GHL_HIPIC_VHMS (2014)
Non-material Changes: 021915
CERTIFICATION REGARDING LOBBYING

The undersigned certifies, to the best of his or her knowledge, that:

1. No Federal appropriated funds have been paid or will be paid to any person by or on behalf of the Practitioner for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of a Member of Congress in connection with the award of any Federal loan, the entering into any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

2. If any funds other than Federal appropriated funds have been paid or will be paid to any person for the purpose of influencing or attempting to influence an officer or employee of any agency, a Member of Congress in connection with the award of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into any cooperative agreement, or the extension, continuation, renewal, amendment or modification of this Federal contract, grant, loan, or cooperative agreement, and the Agreement exceeds $100,000, Practitioner shall complete and submit Standard Form-L.L.L. "Disclosure Form to Reporting Lobby," in accordance with its instructions.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into submission of this certification is a prerequisite for making or entering into this transaction pursuant to U.S.C. Section 1352. The failure to file the required certification shall subject the violator to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

Practitioner

By (Signature)

Name (Print) Date

Organization University Physicians of Brooklyn, Inc.

Address 450 Clarkson Ave.

Brooklyn, NY 11203

Telephone License #:

Email NPI#
The American with Disabilities Act (ADA) Attestation

Provider Name (print): ___________________________ Date: ____________
Provider Signature: ___________________________
Provider Address: ________________________________ Specialty: ________________________________

1. Does the office have at least one wheelchair-accessible path from an entrance to an exam room? Yes No

2. Examination tables and all equipment are accessible to people with disabilities. Yes No

3. If parking is provided, spaces are reserved for people with disabilities, pedestrian ramps at sidewalks, and drop-offs? Yes No

4. If parking is provided, are there an adequate number of parking spaces provided (8 feet wide for a car and 5 foot access aisle)? Yes No

   Total Spaces accessible Spaces
   1-25 1
   26-50 2
   51-75 3
   76-100 4

5. For a provider with a disability-accessible parking space, is there a path of travel from the disability-accessible parking space to the facility entrance that does not require the use of stairs? Yes NO
   • Is the path of travel stable, firm and slip resistant? Yes No
   • Except for curb cuts, is the path at least 36 inches wide? Yes No

6. Is there a method for persons using wheelchairs or that require other mobility assistance to enter as freely as everyone else? Yes No
   • Is that route of travel safe and accessible for everyone, including people with disabilities? Yes No

7. Does the main exterior entrance door used by persons with mobility disabilities to access public spaces meet the following standards:
   • 32 inches clear opening. Yes No
   • 18 inches of clear wall space on the pull side of the door, next to the handle. Yes No
   • The threshold edge is no greater than 1/8 inch high or if beveled, no greater than 1/4 inches high. Yes No
   • The door handle is no higher than 48 inches high and can be operated with a closed fist. Yes No

8. Are there ramps to permit wheelchair access? Yes No
   If yes, complete the following 4 questions:
   • Are the slopes of the ramp accessible for wheelchair access? Yes No
   • Are the railings sturdy and high enough for wheelchair access? Yes No
9. Is the width between railings wide enough to accommodate a wheelchair? Yes No

10. Are the ramps nonslip and free from any obstruction (cracks)? Yes No

11. Are the ramps nonslip and free from any obstruction (cracks)? Yes No

12. Can the accessible entrance be used independently and without assistance? Yes No

13. Do any inaccessible entrances have signs indicating the location of the nearest accessible entrance? Yes No

14. Can the accessible entrance be used independently and without assistance? Yes No

15. Is the accessible entrance be used independently and without assistance? Yes No

16. Are doormats 1/2 inch high or less with beveled or secured edges? Yes No

17. Are waiting rooms and exam rooms accessible to people with disabilities? Yes No

18. Is there a 5 foot circle or a T-shaped space for a disabled person using a wheelchair to reverse direction in public areas where services are rendered? Yes No

19. Are the accessible routes to all public spaces in the facility 32 inches wide? Yes No

20. Do any inaccessible entrances have signs indicating the location of the nearest accessible entrance? Yes No

21. Do any inaccessible entrances have signs indicating the location of the nearest accessible entrance? Yes No

22. Elevators in the facility meet the following standards:
   a. There are raised and Braille signs on both door jambs on every floor. Yes No
   b. The call buttons in the hallway are not higher than 42 inches. Yes No
   c. The controls inside the cab have raised and Braille lettering. Yes No

23. Elevators in the facility meet the following standards:
   a. There are raised and Braille signs on both door jambs on every floor. Yes No
   b. The call buttons in the hallway are not higher than 42 inches. Yes No
   c. The controls inside the cab have raised and Braille lettering. Yes No

24. Are sign language interpreters and other auxiliary aids and services provided in appropriate circumstances? Yes No

25. Is the public lavatory wheelchair-accessible? Yes No

26. With respect to the public restroom, the accessible route, the exterior door and the interior stall doors comply with standards set forth above for exterior doors. Yes No

27. Is there at least one wheelchair-accessible stall in the public restroom that has an area of at least 5 feet by 5 feet, clear of the door swing; OR there is at least one stall that is less accessible but that provides greater access than a typical stall (either 36 by 69 inches, or 48 by 96 inches). Yes No

28. In the accessible stall of the public restroom there are grab bars behind and on the side wall nearest the toilet. Yes No
25. There is one lavatory in the public restroom that meets the following standards:

- 30 inches wide by 48 inches deep per space in front.
- A maximum of 19 inches of the required depth may be under the lavatory. Yes No
- The lavatory rim is no higher than 34 inches. Yes No
- There is at least 29 inches from the floor to the bottom of the lavatory apron. Yes No
- The faucet can be operated with a closed fist. Yes No
- The soap dispenser and hand dryers are within reach and usable with one closed fist. Yes No
- The mirror is mounted with the bottom edge of the reflecting surface 40 inches from the floor or lower. Yes No

I, [First and Last Names, Title, Provider Name], hereby attest that we are a provider that has a physical site at which FIDA Participants might possibly be physically present and that the answers provided are accurate. Also, I do hereby attest that I hold the authority to make these attestations.

Provider Name (print) ___________________________  Date: ___________________________

Provider Signature _______________________________