Attachment A

Provider Credentialing and Re-credentialing Attestation

I, ____________________________________, understand and acknowledge my responsibility to disclose and attest to the Los Angeles County – Department of Public Health - Substance Abuse Prevention and Control (DPH-SAPC) Drug Medi-Cal Organized Delivery System, any information that applies to the below referenced criteria. (Please complete each section below with a brief explanation. Answer "N/A" if it is not applicable.)

1. Any limitations or inabilities that affect the provider's ability to perform any of the position's essential functions, with or without accommodation.

2. A history of loss of license or felony conviction.

3. A history of loss or limitation of privileges or disciplinary activity.

4. A lack of present illegal drug use.

5. The applicant's accuracy and completeness.

If not specified above, none of the applicable history and/or limitations exist. I hereby attest that all statements on this disclosure form are true and complete to the best of my knowledge. Should the DPH-SAPC Credentialing Team discover material proving otherwise, my approved credentials may be subject to reconsideration and/or denial. Additionally, I understand that any false statement or relevant omission may constitute grounds for reduced, suspended and/or terminated ability to render services under the DPH-SAPC system of care.

____ ______________________________

Signature Date

Agency Name: ____

Refusal to sign does not exempt compliance with DPH-SAPC Credentialing Policy nor the applicable regulations.