EXCLUDE PROVIDER/OIG FORM

I certify that I have not been debarred or excluded (or have charges pending) from participation in federal health care programs and have not been convicted of a health care related criminal offense.

I further agree to immediately contact the Volunteer Services Department if this status should change for any reason.

Legal Name (please print)

______________________ ______ ______________________________

First Name Middle Initial Last Name

Address ____

Street City State Zip

Social Security # ___________________________

DOB (mm/dd/yyyy) ______ /_______/__________

____ _________________

Signature of Volunteer Date

____

Volunteer ID #