**RE: Verification of Good Standing and Malpractice Coverage**

Student/Resident Name or Roster provided: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

On behalf of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (University name), I acknowledge and attest to The Hospitals of Providence (“Hospital”) that we own, and have in our possession, a background investigation report on the attached individuals. Such background investigation is satisfactory in that it:

does not reveal any criminal activity;

confirms the individual is not on either the GSA or OIG exclusion lists;

confirms the individual is not listed as a violent sexual offender;

no other aspect of the investigation required by Employer reveals information of concern; and

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I also agree to comply with any information required for Hospital audits/surveys. I will inform the Hospital of any changes to the above criteria, in writing, immediately. I recognize the student/resident may not be allowed to continue his/her educational rotation based on changes to the above criteria.

Each student/resident is required to carry personal health insurance and has documented as such.

All students/residents have successfully completed all required OSHA and HIPAA training. In addition, a current certificate of completion will be provided to you.

This attestation is provided in lieu of providing a copy of the background investigation.

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Must be signed by an individual at least at a Director level

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