New York State Department of Health
Office of Primary Care and Health Systems Management
Center for Health Care Policy and Resource Development
Office of Healthcare Workforce Innovation

Quarterly Reporting of Temporary Health Care Services Agencies and Health Care Technology Platforms

Attestation:
To complete, please enter the organization's legal name, and information required below, and sign before submitting.

Organization: ____

Consistent with the information provided in the quarterly reporting materials for the above referenced statute, the individual authorized by the above-named organization to submit this form attests that the information submitted is true, accurate, and complete to the best of their knowledge. The data collected will be used to register the agency as a temporary health care services agency in New York State. I understand that any falsification, omission, or concealment of information may subject the above-named agency and/or its controlling person(s) to administrative, civil, or criminal liability, penalties, and/or fines.

Name of Person Authorized to Attest: ______________________________

Title of Person: _______________________________

Electronic Signature: _________________________________

Date: ____________________________

The completed and signed attestation must be included with the quarterly report. Any questions should be sent to TempAgencyRegistration@health.ny.gov.