PROVIDER ATTESTATION STATEMENT
Practice Information Sheet Supplement

Applicant______________________________________, D.D.S., hereby makes the following true, accurate and complete statement.
(Name of Dentist)

- Do you have or have been subject to any chronic illness, physical defects, substance abuse or any other issues which would (with or without reasonable accommodation required by the American With Disabilities Act): (a) pose a direct threat to patients, or (b) render you unable to perform any procedures within the scope of privileges and duties as a dental health care provider or within accepted standards of professional performance?
  ❑ Yes ❑ No
- Do you have any physical or mental impairment that would impede your ability, with or without reasonable accommodation, to carry out the scope of your professional duties on behalf of Western Dental Services, Inc.?
  ❑ Yes ❑ No
- Do you have any physical or mental impairment due to chemical dependency/substance abuse?
  ❑ Yes ❑ No
- Do you have any felony or misdemeanor charges pending against you, other than a traffic violation, or have you ever been convicted of a felony, or pleaded “nolo contendere” to a felony? (Note: Conviction(s) will not necessarily disqualify an applicant from employment.)
  ❑ Yes ❑ No
- Have you ever been terminated from employment or arrested for committing a sexual offense?
  ❑ Yes ❑ No
- Have you ever been denied membership, or renewal thereof, or been subject to disciplinary proceedings for a dental (medical) or ethical reason by any dental/professional organization?
  ❑ Yes ❑ No
- Has your license to practice in any jurisdiction, whether completed or still pending, been denied, restricted, limited, suspended, revoked, not renewed; or have you ever been placed under probation, subjected to disciplinary action or otherwise sanctioned, limited or curtailed; or have you voluntarily relinquished any item in anticipation of any of these actions?
  ❑ Yes ❑ No
- Do you currently, or did you in the last two years, engage in the unlawful use of drugs, including the improper use of prescription drugs?
  ❑ Yes ❑ No
- Has your professional liability insurance ever been denied, suspended, revoked, canceled, or not renewed?
  ❑ Yes ❑ No
- Has your Federal and/or State DEA Registration Certificate ever been denied, suspended, canceled or not renewed, or subjected to any disciplinary action?
  ❑ Yes ❑ No
- Has your status as a provider ever been denied, suspended, canceled, sanctioned or has any disciplinary action ever been taken against you, or are you currently under investigation by any municipal, state, federal or any other governmental agency as well as, DHMO, PPO or other prepaid health plan? (e.g. Medicare, Medi-Cal, Medicaid).
  ❑ Yes ❑ No
- Are your privileges or memberships at any hospital, institution (military service) and/or HMO currently under investigation or have they ever been denied, suspended, reduced, or not renewed; or have any other disciplinary proceedings ever been instituted against you?
  ❑ Yes ❑ No
- Have you ever been or are you currently involved in any malpractice (or any other civil) claims/lawsuits, settlements, or judgments? If yes, please provide detailed information on a separate sheet of paper including: docket number of the case, location of the court, the names of the parties, plaintiff(s) and defendant(s), description of the incident(s), date(s) of the incident(s), your involvement, and the current disposition.
  ❑ Yes ❑ No

FOR EACH “YES” RESPONSE, YOU MUST PROVIDE A DETAILED EXPLANATION AND ATTACH TO THIS FORM.
I authorize Western Dental Services, Inc. (WDS) to consult with professional liability carriers and other persons or entities to obtain information concerning my professional qualifications, including competence, ethics and other qualifications. I, the undersigned, hereby certify that the information requested by WDS, is truthful, correct and complete in all respects, and I further understand that the intentional submission of false or misleading information or the withholding of relevant information is grounds for termination as an employee of WDS. The undersigned hereby agrees to notify WDS of any changes in the above information.

Print Name of Dentist	Signature of Dentist (No signature stamps)	Date