

**STATE OF LOUISIANA
LOUISIANA DEPARTMENT OF HEALTH
BUREAU OF HEALTH SERVICES FINANCING**

PROVIDER DISCLOSURE – FEE FOR SERVICE (FFS)

STATE OF LOUISIANA
PARISH OF _____

I hereby certify that I am the _____ [title] and an authorized agent of
_____ [Physician Group/Dental Group].

I further certify that _____ [Physician Group/Dental Group] is not making a donation to any public entity, including, but not limited to, a public hospital or public government that is later used for an intergovernmental transfer to the Louisiana Department of Health.

Witness

[Name]
[Title]
[Physician/Dental Group]

Witness

SWORN AND SUBSCRIBED BEFORE ME, the undersigned Notary Public, on this _____ day of _____, Year _____, at _____, Louisiana.

Notary Public