Pennsylvania Medical Society
Community-Based Physician Grant Program
Physician Attestation

PRACTICE NAME: _____

By executing this attestation, the undersigned confirm that he or she agrees to participate and abide by the parameters of the Grant. The undersigned also acknowledges that any and all questions were answered to his or her satisfaction prior to submitting this application.

Applicant #1

Physician Name (Printed): _____

I hereby attest to the following:

- ☐ I am an independent physician engaged in the full-time patient-facing practice of medicine at the practice listed.
- ☐ I agree to adhere to the conditions under which the funds can and cannot be used.
- ☐ I agree to use the funds explicitly as described in this application.
- ☐ I agree to report how the funds were utilized and the outcomes achieved in the manner prescribed by the Pennsylvania Medical Society.

Physician Signature: _____

Applicant #2

Physician Name (Printed): _____

I hereby attest to the following:

- ☐ I am an independent physician engaged in the full-time patient-facing practice of medicine at the practice listed.
- ☐ I agree to adhere to the conditions under which the funds can and cannot be used.
- ☐ I agree to use the funds explicitly as described in this application.
- ☐ I agree to report how the funds were utilized and the outcomes achieved in the manner prescribed by the Pennsylvania Medical Society.

Physician Signature: _____

Pennsylvania Medical Society
Community-Based Physician Grant Program
Physician Attestation

Applicant #3

Physician Name (Printed): _____

I hereby attest to the following:

- ☐ I am an independent physician engaged in the full-time patient-facing practice of medicine at the practice listed.
- ☐ I agree to adhere to the conditions under which the funds can and cannot be used.
- ☐ I agree to use the funds explicitly as described in this application.
- ☐ I agree to report how the funds were utilized and the outcomes achieved in the manner prescribed by the Pennsylvania Medical Society.

Physician Signature: _____

Applicant #4

Physician Name (Printed): _____

I hereby attest to the following:

- ☐ I am an independent physician engaged in the full-time patient-facing practice of medicine at the practice listed.
- ☐ I agree to adhere to the conditions under which the funds can and cannot be used.
- ☐ I agree to use the funds explicitly as described in this application.
- ☐ I agree to report how the funds were utilized and the outcomes achieved in the manner prescribed by the Pennsylvania Medical Society.

Physician Signature: _____

Pennsylvania Medical Society
Community-Based Physician Grant Program
Physician Attestation

Applicant #5

Physician Name (Printed): _____

I hereby attest to the following:

- ☐ I am an independent physician engaged in the full-time patient-facing practice of medicine at the practice listed.
- ☐ I agree to adhere to the conditions under which the funds can and cannot be used.
- ☐ I agree to use the funds explicitly as described in this application.
- ☐ I agree to report how the funds were utilized and the outcomes achieved in the manner prescribed by the Pennsylvania Medical Society.

Physician Signature: _____

Applicant #6

Physician Name (Printed): _____

I hereby attest to the following:

- ☐ I am an independent physician engaged in the full-time patient-facing practice of medicine at the practice listed.
- ☐ I agree to adhere to the conditions under which the funds can and cannot be used.
- ☐ I agree to use the funds explicitly as described in this application.
- ☐ I agree to report how the funds were utilized and the outcomes achieved in the manner prescribed by the Pennsylvania Medical Society.

Physician Signature: _____

Pennsylvania Medical Society
Community-Based Physician Grant Program
Physician Attestation

Applicant #7

Physician Name (Printed): _____

I hereby attest to the following:

- ☐ I am an independent physician engaged in the full-time patient-facing practice of medicine at the practice listed.
- ☐ I agree to adhere to the conditions under which the funds can and cannot be used.
- ☐ I agree to use the funds explicitly as described in this application.
- ☐ I agree to report how the funds were utilized and the outcomes achieved in the manner prescribed by the Pennsylvania Medical Society.

Physician Signature: _____