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

Registration of Temporary Health Care Services Agencies and Health Care Technology Platforms

Moral Character Attestation

Name of Person Attesting: _____

Name of Agency Applicant: _____

1. Have you ever been found guilty after trial, or pleaded guilty, no contest, or nolo contendere to a crime (felony or misdemeanor) in any court?
   Yes ☐ No ☐

2. Are criminal charges pending against you in any court?
   Yes ☐ No ☐

3. Has any licensing or disciplinary authority refused to issue you a license, or ever revoked, annulled, cancelled, accepted surrender of, suspended, placed on probation, or refused to renew a professional license or certificate held by you now or previously, or ever fined, censured, reprimanded or otherwise disciplined you?
   Yes ☐ No ☐

4. Are charges pending against you in any jurisdiction for any sort of professional misconduct?
   Yes ☐ No ☐

5. Have you ever willfully failed to provide records to any State Licensing authority or to Federal, State or Local law enforcement officials that are required by Federal, State or Local laws?
   Yes ☐ No ☐

6. If yes to any questions listed above, please explain:

7. Do you agree to comply with all laws and regulations applicable to the Registration of Temporary Health Care Services Agencies and Health Care Technology Platforms?
   Yes ☐ No ☐

Consistent with the information provided in the registration materials, I attest that the information submitted is true, accurate, and complete to the best of my knowledge. I understand that the Department may use the information collected on this form to determine whether to register the agency applicant as a temporary health care services agency in New York State. I understand that any falsification, omission, or concealment of information may subject myself and/or the above-named agency applicant to administrative, civil, or criminal liability, penalties, and/or fines.

Name of Person Attesting: _____

Title: _____

Signature: _____

Date: _____

This form must be completed by anyone who has an ownership or controlling interest in the agency applicant and submitted with the registration materials. Any questions should be sent to TempAgencyRegistration@health.ny.gov.