

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Provider/Employee/Volunteer Code of Conduct Certification

This form accompanies the Department of Health and Human Services Provider Code of Conduct. This form must be signed by all Providers, Employees, and Volunteers in the Department of Health and Human Services once a year.

By signing below, I acknowledge that:

I have read and been provided a personal copy of the Department of Health and Human Services Provider Code of Conduct.

I understand the expectations outlined in the Code of Conduct and will strive in good faith to comply with the provisions therein. Any questions or clarifications of the Code of Conduct have been presented and satisfactorily responded to.

Signature of Employee

Date

Print Name: _____

Signature of Employer

Date

Print Name: _____

Program/Facility Name (*if applicable*)

Employer/Program/Facility Address

City

State

Zip