I,_____, am an authorized representative of _____ (Practice). On behalf of the Practice, under penalty of perjury, I acknowledge that:

- The Practice is participating in the Ohio CPC program through a practice partnership as established by the Ohio Administrative Codes Section 5160-19-01.
- The Practice is a member practice of the practice partnership led by _____(Convener) with CPC ID _____(Convener CPC ID), the designated convener for the practice partnership in accordance with Ohio Administrative Code Section 5160-19-01.
- The Practice understands that the practice partnership will be evaluated as a single entity, in accordance with Ohio Administrative Code Sections 5160-19-01 and 5160-19-02.
- The Practice understands that summary-level data for the Practice will be shared by the Ohio Department of Medicaid with each member practice of the practice partnership.

_____
Practice Name

_____
Address

_____
Medicaid Billing ID

_____
Signature

_____
Printed Name

_____
Date