



Telemedicine Practitioner Attestation

Practitioner Name: _____

HCIC Contracted Agency Name: _____

- I have reviewed the HCIC Provider Manual section (10.10) *Use of Telemedicine/Clinical Telemedicine Services*.
- I have completed the orientation requirements as noted in the HCIC Provider Manual section 10.10 *Use of Telemedicine/Clinical Telemedicine Services*.
- I have taken and passed the telemedicine orientation quiz.

I attest that I will abide by all requirements noted in HCIC Provider Manual Policy section 10.10 Use of Telemedicine/Clinical Telemedicine Services as well as any other policies referenced therein.

Practitioner Signature: _____ Date: _____