**Resident Attestation**

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Faculty Name: URGENT CARE CENTER DOWNTOWN UNION SQUARE

Life No. Rate. $110 Fund: IC141061001

**I hereby attest that I have provided personally performed services at Mount Sinai Beth Israel Medical Center:**

FROM TO

(Date):\_\_\_\_\_\_\_\_\_\_\_ (Time): \_\_\_\_\_\_\_\_\_\_\_\_\_ (Date):\_\_\_\_\_\_\_\_\_\_\_ (Time): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Total Hours Worked: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Total Payment: $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Resident’s Name Resident’s Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorized Signature Date

**For Residents:**

“I certify that 1) the rates paid are within fair market value for the services provided and that the payment is for personally performed services, 2) total compensation does not exceed the 75th Percentile of the AAMC adjusted for NYC (including bonuses processed through HRTS), 3) the services provided are outside the scope of the regular responsibilities of the resident, and 3) the above listed individual is a full-time/per diem faculty member of Mount Sinai.”

All non-FPA Clinical Supplements will be paid on a monthly basis in accordance with MSSM payroll policies.