

**PQRI 'Free Software' Program
Participant Letter of Attestation**

To The Medical Society of the State of New York (MSSNY)

I/We have interest in receiving free PQRI Reporting software and will abide by the requirements of participation.

Practice Name: _____ Tax ID of Practice (if any): _____

Address: _____ (Main address if multiple sites)

City / ST / Zip: _____ Tel-No: ____-____-____ County: _____

Practice Type: _____ # of Physicians in Practice: ____ # of Practice Sites: ____ Submission Option: __ G-Code/80% Rule
____ Alternative Method

We satisfy the following requirements: (Please Check) _____ high speed internet connection
_____ will submit 2009 data by January 31, 2010
_____ will report to MSSNY on monthly basis re: experiences
_____ report successful completion of goals according to submission option

| Physician Name (Please Print) | Physician Type (MD, DO) | NPI Number | Physician Signature |
|-------------------------------|----------------------------|------------|---------------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

**PQRI 'Free Software' Program
Participant Letter of Attestation
(cont'd)**

| Physician Name (Please Print) | Physician Type (MD, DO) | NPI Number | Physician Signature |
|-------------------------------|----------------------------|------------|---------------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

Signature of Authorized Practice Representative

____/____/____
Date

Please fax to: Ron Pucherelli, MSSNY HIT Project Administrator at 518-465-0976 or mail the completed form to:

The Medical Society of the State of New York
c/o Ron Pucherelli, HIT Project Administrator,
One Commerce Plaza
Suite 408
Albany NY 12210.