LSU Health Sciences Center – New Orleans
Federal Healthcare Program Eligibility Information

Last Name: _____First:_____ Middle: _____

Department: _____Job Title: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ EmplID: _____

I certify that I am eligible to participate in all federal and state programs and be compensated by federal and state funds.

I understand the information provided will be verified with the U.S. General Services Administration's List of Parties Excluded from Federal Programs, the HHS/OIG List of Excluded Individuals/Entities and other federal and state agencies. If there is a verified positive query from any of these lists, I can be disqualified as a candidate for employment at LSU Health Sciences Center – New Orleans.

I understand that as a condition of my employment, I am required to inform my department head and the Office of Compliance Programs if I become charged, under investigation, or convicted of a criminal offense relating to any Federal or state program while employed at LSUHSC – New Orleans.

The above information is true and complete to the best of my knowledge.

Signature: _____ Date: _____