MMM
Medicare and Much More

2020 Risk Management Training Certification

I certify that I am the authorized representative of my organization with direct or indirect responsibility of all employees, Board of Directors, officials, contracted personnel, providers/physicians, hospitals, contractors, subcontractors, and vendors subscribed in my organization, who have direct or indirect contact with Medicare businesses.

I certify that I have received from MMM of Florida the 2020 Risk Management Training and Risk Management Incident Report Form.

I certify that these documents **will be used without modification** and distributed to all employees and sub-contractors at the time of hiring/contracting, and annually thereafter.

I certify that I will maintain records for at least 10 years of training completion and will provide it to MMM of Florida upon request.

Name of Authorized Representative certifying training _____ Date _____

Please complete the following information. If you do not complete this section, your certification may be considered incomplete.

Organization _____ NPI/EIN _____

Address 1 _____

Address 2 _____

City _____ State ____ Zip _____

Telephone _____ Email Address _____