Exhibit C

CERTIFIED APPLICATION TRAINING– PARTICIPANT ATTESTATION

The purpose of this document is to **1)** identify the individual at _____ who is responsible for managing training requirements; **2)** certify that such training meets Healthix Policy and Privacy requirements and **3)** limit access to any Protected Health Information obtained through the Certified Application to individual users of _____information system who would be eligible to be Authorized Users of the Participant under these Policies and Procedures if they were Accessing Protected Health Information directly through Healthix. Please provide:

Name	
Title	
Email	
Phone #	

ACKNOWLEDGEMENT

I hereby acknowledge and agree that I am responsible for the management of training for Authorized Users of _____prior to allowing access to information obtained from Healthix via the Certified Application. I will work with Healthix to educate Authorized Users about the policies and procedures for Accessing Protected Health Information via the SHIN-NY as governed by Healthix and as specified by the Statewide Collaboration Process. I am aware that Healthix has provided training materials for me to access via https://healthix.org/ca-training/.

I also will ensure that each Authorized User signs a certification that he or she has received training and will comply with Healthix Policies and Procedures. Such certification may be made on a paper form or electronically and shall be retained by _____for at least six years. I will also ensure that each Authorized User undergoes continuing and/or refresher training on an annual basis as a condition of maintaining authorization to Access patient information via the SHIN-NY as governed by Healthix.

If any of the personal information I have provided on this document changes I will inform Healthix immediately. If at any point in time _____wishes to change the individual responsible for the implementation of the Certified Application Training , I will ensure that Healthix is notified and receives a new Certified Application Participant Attestation Form by email to **compliance@healthix.org**. I understand that until this occurs, I will remain responsible for training of Authorized Users via the Certified Application.

_____ _____

Date Signature

CERTIFICATION *To be completed by Healthix staff:*

Healthix hereby certifies that all security and privacy requirements for access to Healthix through a Certified Application have been communicated to and validated by the _____

_____ _____

Compliance Manager Signature