

**PPO – EMPLOYER AFFIRMATION B**

Bureau of Health Management  
State of New York Workers' Compensation Board  
100 Broadway-Menands, Albany, NY 12241

In the Matter of Preferred Provider Organization Participation  
By EMPLOYER (**Please enter name and address**)

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

\_\_\_\_\_

-and-

**UNION** \_\_\_\_\_ (Union Name)

1. I, \_\_\_\_\_ am the \_\_\_\_\_  
(Name of Union Official) (Title of Union Official)  
of \_\_\_\_\_, (“the Union”) which is the recognized or  
(Name of Union)  
exclusive collective bargaining representative for the members of the Union who are employed by  
\_\_\_\_\_ (“the Employer”) and who will be covered by this Preferred  
(Name of Employer)  
Provider Organization (“PPO”) arrangement. I file this affirmation in accordance with Article 10-A of  
the Workers’ Compensation Law and 12 NYCRR 325-8.2.

2. I, \_\_\_\_\_ am the \_\_\_\_\_ of the  
(Name of Employer Official) (Title)  
employer and I file this affirmation in accordance with Article 10-A of the Workers’ Compensation Law  
and 12 NYCRR 325-8.2.

3. We affirm that the Employer and the Union engaged in negotiations with respect to the selection of a  
certified PPO network and have agreed to have \_\_\_\_\_  
(Name of PPO )  
as the exclusive source for all initial treatment of work-related injuries and illnesses suffered by  
members of the Union.

4. We affirm that the duration of this PPO agreement is from \_\_\_\_\_ to \_\_\_\_\_ .  
Any subsequent agreements will be made subject to the same prior review and approval process by the  
Employer and the Union.

\_\_\_\_\_  
Signature of Union Official

\_\_\_\_\_  
Signature of Employer Official

\_\_\_\_\_  
(Please type or print union official name)

\_\_\_\_\_  
(Please type or print employer official name)

Sworn to me this day of \_\_\_\_\_.

Notary Signature and Stamp