Clinic Compliance Acknowledgment Form

To be signed by each participating clinic or physician office.

Wound Care Skin Substitute Program
Compliance Acknowledgment Form

Clinic/Physician Name: _____
Clinic Address: _____
Point of Contact: _____
Phone: _____ **Email:** _____

Acknowledgment of Compliance Responsibilities

By signing below, the clinic affirms its understanding and acceptance of the following terms:

1. **Inventory Management**
    a. Maintain accurate logs for all grafts (including product name, Q-code, serial number, date received and assigned patient).
    b. Store products according to manufacturer guidelines.
2. **Usage Documentation & Reporting**
    a. Report all graft usage (including partial use, waste, or full application) using required forms.
    b. Include graft ID and patient details in each usage report and billing.
3. **Return Policy & Financial Responsibility**
    a. Return unused grafts within the designated time frame.
    b. Pay full ASP for any unreturned, misused, or expired grafts.
4. **Restricted Use Policy**
    a. Use grafts **only** for approved PMC members with prior authorization.
    b. Prohibited use outside of PMC scope will result in full ASP liability and possible termination of participation.

5. **Audit & Enforcement**
    a. Understand that PMC reserves the right to audit inventory, usage records, and billing to ensure compliance.

Authorized Clinic Representative
Printed Name: _____
Signature: _____
Title: _____ **Date:** _____

Return signed form to PMC Wound Care Compliance Department.