Lexington Clinic Initial Credentialing/Privileging Packet Instructions

Lexington Clinic Forms

- Page 1 is just for your records.
- Please enter demographic information and background check information and sign as highlighted on pages 2-5.
- Sign page 9.
- Sign pages 11-13 (I will use the work history information that you enter onto your KAPER for the work history form on page 12, so you only need to sign this form and you do not need to fill in anything further).

Lexington Clinic

Provider RIGHTS

CREDENTIALING/RECREDENTIALING PROCESS

1. **You have the right to review information submitted in support of your credentialing application.**
   This includes information received from any outside source with the exception of references, recommendations, or other peer-reviewed information.

2. **You have the right to correct erroneous information.**
   Any information that varies substantially from that provided by the provider will be shared with the provider. The provider has the right to correct erroneous information submitted by other sources if not protected by law or protected by peer review. The information allowed to be shared with the provider does not include that about references, recommendations, or other peer review protected information. Notification will be sent in writing/electronically to the provider and the provider will be given 15 days to submit corrections in writing/electronically to the Credentialing Department (Credentialing Manager/Supervisor).

3. **You have the right to receive the status of your credentialing or recredentialing application upon request.**
   Inquiries and responses regarding credentialing or recredentialing application processing status may be made by phone, letter, or email.

Lexington Clinic

New Hire Additional Information

Name:		**Date of Birth (NOT TODAY'S DATE):**	
Street Address (NOT PO BOX):			
City:		**County:**	
State:		**Zip:**	
United States Citizen	☐ Yes ☐ No	**Gender:**	☐ Male ☐ Female

Race:

- ❑ White (Not of Hispanic origin)
- ❑ Black (Not of Hispanic origin)
- ❑ Hispanic
- ❑ Asian or Pacific Islander
- ❑ American Indian or Alaskan Native

Marital Status:

- ❑ Single
- ❑ Married
- ❑ Widowed
- ❑ Divorced

Veteran Status: (check all that apply)

❑ **Special Disabled Veteran** – refers to a veteran who is entitled to compensation (or who, but for the receipt of military retired pay, would be entitled to compensation) under laws administered by the Dept of Veterans Affairs for a disability rated at 30% or more, or rated at 10% or 20% in the case of a veteran who has been determined by the Dept of Veterans Affairs to have a serious employment handicap. The term also refers to a person who was discharged or released from active duty because of service-connected disability.

❑ **Vietnam Veteran** - Persons who served on active duty for more than 180 days, and was discharged or released there from with other than a dishonorable discharge, if any part of such active duty occurred in the Republic of Vietnam between February 28, 1961, and May 7, 1975, or between August 5, 1964, and May 7, 1975, in all other cases. The term also refers to person who was discharged or released from active duty for a service-connected disability if any part of such active duty was performed in the Republic of Vietnam between February 28, 1961, and May 7, 1975 or between August 5, 1964, and May 7, 1975, in all other cases.

❑ **Newly Separated Veteran** – Hire date is within one year of being discharged or released from active duty.

❑ **Other Veteran** - Served on active duty in the U.S. military, ground, naval or air service during a war or in a campaign or expedition for which a campaign badge has been authorized. Campaign list available upon request.

Disability Status:

Do you categorize yourself as having a disability – physical, sensory, or mental condition that substantially, rather than slightly, limits any of your major life functions such as: walking, speaking, seeing, hearing, breathing, working, learning, caring for oneself or performing manual tasks? ☐ Yes ☐ No

Foreign Language & Sign Language Capability:

Language: ______________________________ ☐ Speak ☐ Read ☐ Fluent

Language: ______________________________ ☐ Speak ☐ Read ☐ Fluent

Fluent in Sign Language? ☐ Yes ☐ No

Dear Applicant:

Every day, employees at Lexington Clinic are entrusted with patients' well-being. In addition, patients trust us with their health, financial and other personal information. In order to ensure the highest level of care, protect the safety of our patients, and ensure the protection of their information and property, Lexington Clinic takes reasonable steps to employ individuals who are honest, caring, and trustworthy, including performing background checks on applicants for employment.

As part of these efforts, individuals who are being considered for employment are asked to disclose all criminal convictions (other than minor traffic violations). Please complete the below information honestly. Please note that not all criminal convictions will result in an adverse decision. However, providing false or untruthful information will result in the denial of an offer of employment or termination of employment if subsequently discovered.

Have you ever been convicted of, or pled guilty or no contest to, a crime (other than a minor traffic violation)? ____ yes ______no

If yes, please identify each conviction, the approximate date and court, and provide any explanation that should be considered:

____
____
____
____

I certify that the above information is true and correct. I understand that providing false information will be grounds for refusal of hire and/or termination of employment if hired.

____
Applicant signature

BACKGROUND SCREENING RELEASE & AUTHORIZATION FORM

In connection with my application for employment (including contract for services or volunteer services) or tenancy with **Lexington Clinic/Physician Services**, consumer reports will be requested. These consumer reports (investigative consumer reports in California) may include, as applicable, the following types of information: names and dates of previous employers/landlords, salary, work/tenant experience, education, accidents, licensure, credit (except California), social media, etc. I further understand that such reports may contain public record information such as, but not limited to: my driving record, workers' compensation claims, judgments, evictions, bankruptcy proceedings, criminal records, etc., from federal, state and other agencies which maintain such records.

In addition, investigative consumer reports as defined by the federal Fair Credit Reporting Act, gathered from personal interviews with former employers/landlords and other past or current associates of mine to gather information regarding my work/tenant performance, character, general reputation, personal characteristics and lifestyle may be obtained.

I AUTHORIZE, WITHOUT RESERVATION, ANY PARTY OR AGENCY CONTACTED BY THE CONSUMER REPORTING AGENCY TO FURNISH THE ABOVE-MENTIONED INFORMATION.

I have the right to make a request to the consumer reporting agency: VeriCorp, Inc., P.O. Box 436054, Louisville, KY 40253-6054; telephone (877) 717-3515 ("Agency"), upon proper identification, to request the nature and substance of all information in its files on me at the time of my request, including the sources of information and the agency, on our behalf, will provide a complete and accurate disclosure of the nature and scope of the investigation covered by any consumer report(s); and the recipients of any reports on me which the agency has previously furnished within the two year period for employment requests, and one year for other purposes preceding my request (California three years). **I hereby consent to your obtaining the above information from the agency.** You may view their privacy policy at their website: www.vericorphr.com.

I hereby authorize procurement of consumer report(s) and investigative consumer report(s), including the release of all criminal history records. If hired (or contracted), this authorization shall remain on file and shall serve as ongoing authorization for you to procure consumer reports at any time during my employment (or contract) period.

☐ California, Minnesota and Oklahoma Applicants only: Check box if you request a copy of any consumer report ordered on you.

Notice to California Applicants:

You have the right under Section 1786.22 of the California Civil Code to contact the Agency during reasonable hours (9:00 a.m. to 5:00 p.m. (ETZ) Monday through Friday) to obtain all information in your file for your review. You may obtain such information as follows: 1) In person at the Agency's offices, which address is listed above. You can have someone accompany you to the Agency's offices. Agency may require this third party to present reasonable identification. You may be required at the time of such visit to sign an authorization for Agency to disclose to or discuss your information with this third party; 2) By certified mail, if you have previously provided identification in a written request that your file be sent to you or to a third party identified by you; 3) By telephone, if you have previously provided proper identification in writing to Agency; and 4) Agency has trained personnel to explain any information in your file to you and if the file contains any information that is coded, such will be explained to you.

Notice to New York Applicants:

For consumers applying for work in New York: I acknowledge receiving a copy of Article 23-A of the New York Correction Law. ____(Initials)

I acknowledge that I have been provided a copy of consumer's rights under the Fair Credit Reporting Act.

APPLICANT SIGNATURE:______________________________ **DATE:** ________________

Rev. 09.18

Applicant Information provided below:

Please Print Clearly

FIRST NAME	MIDDLE NAME	LAST NAME	
SOCIAL SECURITY NUMBER	DATE OF BIRTH (mm/dd/yyyy)	PLEASE CHECK ONE	
		MALE ☐ FEMALE ☐	

Alias/Maiden/Previous Name(s) Use the back of this form if more space is needed.

FIRST NAME	MIDDLE NAME	LAST NAME	YEARS USED

List all addresses, *including current address*, for the past 7 years. Use the back of this form if more space is needed.

ADDRESS	CITY	STATE	COUNTY & ZIP CODE	DATES TO - FROM

Complete if applying for a position that may involve driving a motor vehicle.

DRIVERS LICENSE NUMBER	STATE ISSUED	EXPIRATION DATE

EMAIL ADDRESS (If you wish to be contacted this way)

Para información en español, visite www.consumerfinance.gov/learnmore o escribe a la Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, DC 20552.

A Summary of Your Rights Under the Fair Credit Reporting Act

The federal Fair Credit Reporting Act (FCRA) promotes the accuracy, fairness, and privacy of information in the files of consumer reporting agencies. There are many types of consumer reporting agencies, including credit bureaus and specialty agencies (such as agencies that sell information about check writing histories, medical records, and rental history records). Here is a summary of your major rights under the FCRA. **For more information, including information about additional rights, go to www.consumerfinance.gov/learnmore or write to: Consumer Financial Protection Bureau, 1700 G Street N.W., Washington, DC 20552.**

• **You must be told if information in your file has been used against you.** Anyone who uses a credit report or another type of consumer report to deny your application for credit, insurance, or employment – or to take another adverse action against you – must tell you, and must give you the name, address, and phone number of the agency that provided the information.

• **You have the right to know what is in your file.** You may request and obtain all the information about you in the files of a consumer reporting agency (your "file disclosure"). You will be required to provide proper identification, which may include your Social Security number. In many cases, the disclosure will be free. You are entitled to a free file disclosure if:

- a person has taken adverse action against you because of information in your credit report;
- you are the victim of identify theft and place a fraud alert in your file;
- your file contains inaccurate information as a result of fraud;
- you are on public assistance;
- you are unemployed but expect to apply for employment within 60 days.

In addition, all consumers are entitled to one free disclosure every 12 months upon request from each nationwide credit bureau and from nationwide specialty consumer reporting agencies. See www.consumerfinance.gov/learnmore for additional information.

• **You have the right to ask for a credit score.** Credit scores are numerical summaries of your credit-worthiness based on information from credit bureaus. You may request a credit score from consumer reporting agencies that create scores or distribute scores used in residential real property loans, but you will have to pay for it. In some mortgage transactions, you will receive credit score information for free from the mortgage lender.

• **You have the right to dispute incomplete or inaccurate information.** If you identify information in your file that is incomplete or inaccurate, and report it to the consumer reporting agency, the agency must investigate unless your dispute is frivolous. See www.consumerfinance.gov/learnmore for an explanation of dispute procedures.

• **Consumer reporting agencies must correct or delete inaccurate, incomplete, or unverifiable information.** Inaccurate, incomplete or unverifiable information must be removed

or corrected, usually within 30 days. However, a consumer reporting agency may continue to report information it has verified as accurate.

• **Consumer reporting agencies may not report outdated negative information.** In most cases, a consumer reporting agency may not report negative information that is more than seven years old, or bankruptcies that are more than 10 years old.

• **Access to your file is limited.** A consumer reporting agency may provide information about you only to people with a valid need – usually to consider an application with a creditor, insurer, employer, landlord, or other business. The FCRA specifies those with a valid need for access.

• **You must give your consent for reports to be provided to employers.** A consumer reporting agency may not give out information about you to your employer, or a potential employer, without your written consent given to the employer. Written consent generally is not required in the trucking industry. For more information, go to www.consumerfinance.gov/learnmore.

• **You may limit "prescreened" offers of credit and insurance you get based on information in your credit report.** Unsolicited "prescreened" offers for credit and insurance must include a toll-free phone number you can call if you choose to remove your name and address from the lists these offers are based on. You may opt-out with the nationwide credit bureaus at 1-888-567-8688.

• **You may seek damages from violators.** If a consumer reporting agency, or, in some cases, a user of consumer reports or a furnisher of information to a consumer reporting agency violates the FCRA, you may be able to sue in state or federal court.

• **Identity theft victims and active duty military personnel have additional rights.** For more information, visit www.consumerfinance.gov/learnmore.

• **Consumers have the right to obtain a security freeze.** You have a right to place a "security freeze" on your credit report, which will prohibit a consumer reporting agency from releasing information in your credit report without your express authorization. The security freeze is designed to prevent credit, loans, and services from being approved in your name without your consent. However, you should be aware that using a security freeze to take control over who gets access to the personal and financial information in your credit report may delay, interfere with, or prohibit the timely approval of any subsequent request or application you make regarding a new loan, credit, mortgage, or any other account involving the extension of credit. As an alternative to a security freeze, you have the right to place an initial or extended fraud alert on your credit file at no cost. An initial fraud alert is a 1-year alert that is placed on a consumer's credit file. Upon seeing a fraud alert display on a consumer's credit file, a business is required to take steps to verify the consumer's identity before extending new credit. If you are a victim of identity theft, you are entitled to an extended fraud alert, which is a fraud alert lasting 7 years. A security freeze does not apply to a person or entity, or its affiliates, or collection agencies acting on behalf of the person or entity, with which you have an existing account that requests information in your credit report for the purposes of reviewing or collecting the account. Reviewing the account includes activities related to account maintenance, monitoring, credit line increases, and account upgrades and enhancements.

States may enforce the FCRA, and many states have their own consumer reporting laws. In some cases, you may have more rights under state law. For more information, contact your state or local consumer protection agency or your state Attorney General. For information about your federal rights, contact:

TYPE OF BUSINESS:	CONTACT:
1.a. Banks, savings associations, and credit unions with total assets of over $10 billion and their affiliates.	a. Consumer Financial Protection Bureau 1700 G Street NW Washington, DC 20552
b. Such affiliates that are not banks, savings associations, or credit unions also should list, in addition to the CFPB:	b. Federal Trade Commission: Consumer Response Center – FCRA Washington, DC 20580 (877) 382-4357
2. To the extent not included in item 1 above: a. National banks, federal savings associations, and federal branches and federal agencies of foreign banks	a. Office of the Comptroller of the Currency Customer Assistance Group 1301 McKinney Street, Suite 3450 Houston, TX 77010-9050
b. State member banks, branches and agencies of foreign banks (other than federal branches, federal agencies, and Insured State Branches of Foreign Banks), commercial lending companies owned or controlled by foreign banks, and organizations operating under section 25 or 25A of the Federal Reserve Act	b. Federal Reserve Consumer Help Center P.O. Box 1200 Minneapolis, MN 55480
c. Nonmember Insured Banks, Insured State Branches of Foreign Banks, and insured state savings associations	c. FDIC Consumer Response Center 1100 Walnut Street, Box #11 Kansas City, MO 64106
d. Federal Credit Unions	d. National Credit Union Administration Office of Consumer Protection (OCP) Division of Consumer Compliance and Outreach (DCCO) 1775 Duke Street Alexandria, VA 22314
3. Air carriers	Asst. General Counsel for Aviation Enforcement & Proceedings Aviation Consumer Protection Division Department of Transportation 1200 New Jersey Avenue, SE Washington, DC 20590
4. Creditors Subject to Surface Transportation Board	Office of Proceedings, Surface Transportation Board Department of Transportation 395 E Street S.W. Washington, DC 20423
5. Creditors Subject to Packers and Stockyards Act, 1921	Nearest Packers and Stockyards Administration area supervisor
6. Small Business Investment Companies	Associate Deputy Administrator for Capital Access United States Small Business Administration 409 Third Street, SW, 8th Floor Washington, DC 20416
7. Brokers and Dealers	Securities and Exchange Commission 100 F St NE Washington, DC 20549
8. Federal Land Banks, Federal Land Bank Associations, Federal Intermediate Credit Banks, and Production Credit Associations	Farm Credit Administration 1501 Farm Credit Drive McLean, VA 22102-5090
9. Retailers, Finance Companies, and All Other Creditors Not Listed Above	FTC Regional Office for region in which the creditor operates or Federal Trade Commission: Consumer Response Center – FCRA Washington, DC 20580 (877) 382-4357

Lexington Clinic

Emergency Medicine

Initial Appointment ☒
Reappointment ☐

NAME: ________________________________

Privileges include work up, diagnosis and treatment of medical conditions, illnesses, injuries or disorders and the ability to perform any procedures known and acceptable to the general field of medicine in an emergency situation. Consultation will be sought as needed.

Instructions: Please place a ✓ in the "Requested by Applicant" column to identify each privilege requested. If requesting other privileges, please write the specific procedure under "other privileges."

Privileges Requested Classification/Procedure	*Requested by Applicant*	*Approval*	Comments
Emergency Medicine			
Evaluation and management of patients admitted to the Emergency Department.	X		
Saint Joseph Hospital Privileging Information	*Applicant's Privileges at Saint Joseph Hospital Attached*		**Comments**
Lexington Clinic Emergency Medicine providers treat patients at Saint Joseph Hospitals located in Kentucky. A copy of the provider's current approved privileges, or current pending privileges, at Saint Joseph Hospital is attached.			

I hereby request the privileges for the above-listed and all procedures applicable to my specialty in which I am fully trained and agree to practice within the scope of my specialty.
I am free of any acute or chronic physical or mental illness that would prevent me from discharging my duties or would endanger the welfare and/or health of my patients.

Applicant (Printed Name) **Signature** **Date**

Peer/Training Director or Head of Section (Printed Name) **Signature** **Date**

Approved ☐
Approved as Amended ☐
Denied ☐

Lexington Clinic

Emergency Medicine

Initial Appointment ❑
Reappointment ❑

NAME: ______________________________

Robert L. Bratton, MD, CPE, MMM

Credentialing Committee Chair (Printed Name)	Signature	Date	
			Approved ☐ Approved as Amended ☐ Denied ☐

Michael Cecil, MD

Board Chair (Printed Name)	Signature	Date	
			Approved ☐ Approved as Amended ☐ Denied ☐

Provisional Privileges

Provider's application has no imminent issues and provisional privileges are granted.

Dates

From: **To:**

Robert L. Bratton, MD, CPE, MMM

Credentialing Committee Chair (Printed Name)	Signature	Date	
			Approved ☐ Approved as Amended ☐ Denied ☐

CONTINUING EDUCATION ATTESTATION

Continuing Education Requirements:

I have received continuing education appropriate to maintain Kentucky licensure and ensure proficiency of the clinical privileges within my specialty that I am requesting. Furthermore, I will maintain the documentation of this education and provide this documentation to Lexington Clinic Physician Services immediately upon request.

I have completed the required number of CMEs or CEUs in the past two years directly related to my specialty as required by the Kentucky Board of Medical Licensure in accordance with Board regulation 201 KAR 9:310, or other applicable KY Licensing Board requirements.

This form is in lieu of providing certificates and/or listings of CMEs requested in Section III, page 4 of the Kaper Application

____
Printed Name

____ ____________________
Signature Date

Lexington Clinic

WORK HISTORY

Please provide work history information for the past ten (10) years.

Please explain any gaps longer than 30 days.

Practice/Employer Name: ______________________________
Number and Street: ______________________________
City: ____________________ State: __________ Zip: __________
Start Date (MM/YY): ____________ End Date (MM/YY): ____________

Practice/Employer Name: ______________________________
Number and Street: ______________________________
City: ____________________ State: __________ Zip: __________
Start Date (MM/YY): ____________ End Date (MM/YY): ____________

Practice/Employer Name: ______________________________
Number and Street: ______________________________
City: ____________________ State: __________ Zip: __________
Start Date (MM/YY): ____________ End Date (MM/YY): ____________

Practice/Employer Name: ______________________________
Number and Street: ______________________________
City: ____________________ State: __________ Zip: __________
Start Date (MM/YY): ____________ End Date (MM/YY): ____________

Practice/Employer Name: ______________________________
Number and Street: ______________________________
City: ____________________ State: __________ Zip: __________
Start Date (MM/YY): ____________ End Date (MM/YY): ____________

I attest that this information is correct and complete.

______________________________ ____________________
Signature Date

Standard Authorization, Attestation and Release

(Not for Use for Employment Purposes)

I understand and agree that, as part of the credentialing application process for participation, membership and/or clinical privileges (hereinafter, referred to as "Participation") at or with each healthcare organization indicated on the "List of Authorized Organizations" that accompanies this Provider Application (hereinafter, each healthcare organization on the "List of Authorized Organizations" is individually referred to as the "Entity"), and any of the Entity's affiliated entities, I am required to provide sufficient and accurate information for a proper evaluation of my current licensure, relevant training and/or experience, clinical competence, health status, character, ethics, and any other criteria used by the Entity for determining initial and ongoing eligibility for Participation. Each Entity and its representatives, employees, and agent(s) acknowledge that the information obtained relating to the application process will be held confidential to the extent permitted by law.

I acknowledge that each Entity has its own criteria for acceptance, and I may be accepted or rejected by each independently. I further acknowledge and understand that my cooperation in obtaining information and my consent to the release of information do not guarantee that any Entity will grant me clinical privileges or contract with me as a provider of services. I understand that my application for Participation with the Entity is not an application for employment with the Entity and that acceptance of my application by the Entity will not result in my employment by the Entity.

Authorization of Investigation Concerning Application for Participation. I authorize the following individuals including, without limitation, the Entity, its representatives, employees, and/or designated agent(s); the Entity's affiliated entities and their representatives, employees, and/or designated agents; and the Entity's designated professional credentials verification organization (collectively referred to as "Agents"), to investigate information, which includes both oral and written statements, records, and documents, concerning my application for Participation. I agree to allow the Entity and/or its Agent(s) to inspect and copy all records and documents relating to such an investigation.

Authorization of Third-Party Sources to Release Information Concerning Application for Participation. I authorize any third party, including, but not limited to, individuals, agencies, medical groups responsible for credentials verification, corporations, companies, employers, former employers, hospitals, health plans, health maintenance organizations, managed care organizations, law enforcement or licensing agencies, insurance companies, educational and other institutions, military services, medical credentialing and accreditation agencies, professional medical societies, the Federation of State Medical Boards, the National Practitioner Data Bank, and the Health Care Integrity and Protection Data Bank, to release to the Entity and/or its Agent(s), information, including otherwise privileged or confidential information, concerning my professional qualifications, credentials, clinical competence, quality assurance and utilization data, character, mental condition, physical condition, alcohol or chemical dependency diagnosis and treatment, ethics, behavior, or any other matter reasonably having a bearing on my qualifications for Participation in, or with, the Entity. I authorize my current and past professional liability carrier(s) to release my history of claims that have been made and/or are currently pending against me. I specifically waive written notice from any entities and individuals who provide information based upon this Authorization, Attestation and Release.

Authorization of Release and Exchange of Disciplinary Information. I hereby further authorize any third party at which I currently have Participation or had Participation and/or each third party's agents to release "Disciplinary Information," as defined below, to the Entity and/or its Agent(s). I hereby further authorize the Agent(s) to release Disciplinary Information about any disciplinary action taken against me to its participating Entities at which I have Participation, and as may be otherwise required by law. As used herein, "Disciplinary Information" means information concerning (i) any action taken by such health care organizations, their administrators, or their medical or other committees to revoke, deny, suspend, restrict, or condition my Participation or impose a corrective action plan; (ii) any other disciplinary action involving me, including, but not limited to, discipline in the employment context; or (iii) my resignation prior to the conclusion of any disciplinary proceedings or prior to the commencement of formal charges, but after I have knowledge that such formal charges were being (or are being) contemplated and/or were (or are) in preparation.

Release from Liability. I release from all liability and hold harmless any Entity, its Agent(s), and any other third party for their acts performed in good faith and without malice unless such acts are due to the gross negligence or willful misconduct of the Entity, its Agent(s), or other third party in connection with the gathering, release and exchange of, and reliance upon, information used in accordance with this Authorization, Attestation and Release. I further agree not to sue any Entity, any Agent(s), or any other third party for their acts, defamation or any other claims based on statements made in good faith and without malice or misconduct of such Entity, Agent(s) or third party in connection with the credentialing process. This release shall be in addition to, and in no way shall limit, any other applicable immunities provided by law for peer review and credentialing activities. In this Authorization, Attestation and Release, all references to the Entity, its Agent(s), and/or other third party include their respective employees, directors, officers, advisors, counsel, and agents. The Entity or any of its affiliates or agents retains the right to allow access to the application information for purposes of a credentialing audit to customers and/or their auditors to the extent required in connection with an audit of the credentialing processes and provided that the customer and/or their auditor executes an appropriate confidentiality agreement. I understand and agree that this Authorization, Attestation and Release is irrevocable for any period during which I am an applicant for Participation at an Entity, a member of an Entity's medical or health care staff, or a participating provider of an Entity. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. I understand that my failure to promptly provide another consent may be grounds for termination or discipline by the Entity in accordance with the applicable bylaws, rules, and regulations, and requirements of the Entity, or grounds for my termination of Participation at or with the Entity. I agree that information obtained in accordance with the provisions of this Authorization, Attestation and Release is not and will not be a violation of my privacy.

I certify that all information provided by me in my application is current, true, correct, accurate and complete to the best of my knowledge and belief, and is furnished in good faith. I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information (including any changes/challenges to licenses, DEA, insurance, malpractice claims, NPDB/HIPDB reports, discipline, criminal convictions, etc.) I have provided in my application or authorized to be released pursuant to the credentialing process. I understand that corrections to the application are permitted at any time prior to a determination of Participation by the Entity, and must be submitted online or in writing, and must be dated and signed by me (may be a written or an electronic signature). I acknowledge that the Entity will not process an application until they deem it to be a complete application and that I am responsible to provide a complete application and to produce adequate and timely information for resolving questions that arise in the application process. I understand and agree that any material misstatement or omission in the application may constitute grounds for withdrawal of the application from consideration; denial or revocation of Participation; and/or immediate suspension or termination of Participation. This action may be disclosed to the Entity and/or its Agent(s). I further acknowledge that I have read and understand the foregoing Authorization, Attestation and Release and that I have access to the bylaws of applicable medical staff organizations and agree to abide by these bylaws, rules and regulations. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

Signature* ______________________

Name (print)* ______________________

M M D D Y Y Y Y

DATE SIGNED*