Excelsior Medical IPA, LLC

STANDARD APPLICATION FORM

PLEASE TYPE OR PRINT

Section 1- General Information

NAME (LAST, FIRST, MIDDLE) | GENDER ☐ M ☐ F

DATE OF BIRTH | SOCIAL SECURITY NO.

HOME ADDRESS/STREET

CITY | STATE | ZIP

Applying As: ☐ Primary Care Physician ☐ Specialist Physician ☐ Both

REQUESTED SPECIALTY | REQUESTED SPECIALTY | REQUESTED SPECIALTY

PRIMARY LOCATION Please attach additional sheet for other locations.	**OTHER LOCATION(S)** Please attach additional sheet for other locations.
GROUP PRACTICE NAME (IF APPLICABLE)	GROUP PRACTICE NAME (IF APPLICABLE)
STREET	STREET
CITY	CITY
STATE / ZIP	STATE / ZIP
COUNTY	COUNTY
TELEPHONE	TELEPHONE
FAX	FAX
CREDENTIALING CONTACT	CREDENTIALING CONTACT
BILLING ADDRESS/STREET	BILLING ADDRESS/STREET
CITY	CITY
STATE / ZIP	STATE / ZIP
TELEPHONE ( ) -	TELEPHONE ( ) -
TAX ID NUMBER	TAX ID NUMBER

OFFICE HOURS	MONDAY	TUESDAY	WEDNESDAY
THURSDAY	FRIDAY	SATURDAY	SUNDAY

OFFICE HOURS	MONDAY	TUESDAY	WEDNESDAY
THURSDAY	FRIDAY	SATURDAY	SUNDAY

WHAT HOURS/DAYS ARE YOU AVAILABLE TO SEE PATIENTS?	WHAT HOURS/DAYS ARE YOU AVAILABLE TO SEE PATIENTS?
IS YOUR OFFICE HANDICAPPED ACCESSIBLE? ☐ Yes ☐ No	IS YOUR OFFICE HANDICAPPED ACCESSIBLE? ☐ Yes ☐ No
LIST LANGUAGES OTHER THAN ENGLISH SPOKEN BY **PHYSICIAN**	LIST LANGUAGES OTHER THAN ENGLISH SPOKEN BY **PHYSICIAN**
LIST LANGUAGES OTHER THAN ENGLISH SPOKEN BY **OFFICE STAFF**	LIST LANGUAGES OTHER THAN ENGLISH SPOKEN BY **OFFICE STAFF**

Section 2- Practice Information

YEAR PRACTICE STARTED	MEDICARE NUMBER (for practice)	MEDICAID NUMBER (for practice)

Type of Practice ☐ Solo ☐ Group ☐ Other ☐ Multi-Specialty Group

LICENSE STATE	LICENSE NUMBER	EXPIRATION DATE

Do you have licenses in any other states or countries? ☐ Yes ☐ No Please list:

STATE/COUNTY	LICENSE NUMBER	EXPIRATION DATE

NPI	GROUP NPI	CAQH ID #

MEDICARE	UPIN	MEDICAID

DEA NUMBER	EXP.DATE	FEDERAL TAX ID NUMBER

Is DEA number ☐ Unlimited or ☐ Restricted?	IF RESTRICTED, PLEASE EXPLAIN.

DOCTOR'S CELL NUMBER:	DOCTOR'S EMAIL ADDRESS:

Names and Specialites of other members in your group *if you need additional space, please attach sheets.*

NAME	SPECIALTY
NAME	SPECIALTY
NAME	SPECIALTY
NAME	SPECIALTY

YOUR REIMBURSEMENT CHECKS SHOULD BE MADE PAYABLE TO: *(if more than one billing address or Tax ID, list on separate page)*

AND MAILED TO: ADDRESS/STREET	CITY	STATE	ZIP

Age range of patients you will see:

Are you currently accepting new patients? ☐ Yes ☐ No

Do you expect the size of your practice to preclude you from accepting new patients anytime within the next year? ☐ Yes ☐ No

Do you make housecalls? ☐ Yes ☐ No

How many days to obtain an appointment in your office for

Non-urgent visits? Urgent problem? New patient/no symptoms?

Will you provide second opinions? ☐ Yes ☐ No

Do you treat Workers' Compensation patients? ☐ Yes ☐ No

Do you offer 24-hour coverage for your patients? ☐ Yes ☐ No

If yes, How?

Covering physicians should be participating providers or be in the process of becoming providers in the plan you are applying to. Please list covering physician(s). If aditional names and information, please attach.

NAME		NAME		NAME	
STREET ADDRESS		STREET ADDRESS		STREET ADDRESS	
CITY		CITY		CITY	
STATE	ZIP	STATE	ZIP	STATE	ZIP
TELEPHONE		TELEPHONE		TELEPHONE	
DEA NUMBER	EXP. DATE	DEA NUMBER	EXP. DATE	DEA NUMBER	EXP. DATE
FEDERAL TAX ID NUMBER		FEDERAL TAX ID NUMBER		FEDERAL TAX ID NUMBER	
Is DEA number Unlimited or Restricted?		Is DEA number Unlimited or Restricted?		Is DEA number Unlimited or Restricted?	
IF RESTRICTED, PLEASE EXPLAIN.		IF RESTRICTED, PLEASE EXPLAIN.		IF RESTRICTED, PLEASE EXPLAIN.	

Briefly describe your practice, including special areas of competence. Please provide copies of certification and other appropriate documentation. If you need additional space, please attach.

Do you perform Surgery in your office? ☐ Yes ☐ No

If yes, list the types of surgery:

Do you have any allied health professionals providing patient care in your practice (e.g., physician's assistant, nurse practitioner, certified nurse anesthetist, certified nurse midwife, audiologist, psychologist or physical therapist)? If yes, please identify below ☐ Yes ☐ No

NAME	TYPE	STATE	LICENSE NO.	EXP. DATE
NAME	TYPE	STATE	LICENSE NO.	EXP. DATE
NAME	TYPE	STATE	LICENSE NO.	EXP. DATE
NAME	TYPE	STATE	LICENSE NO.	EXP. DATE
NAME	TYPE	STATE	LICENSE NO.	EXP. DATE

Do you maintain their current credentials, licenses and malpractice information? ☐ Yes ☐ No

If yes, How often do you recredential them? ☐ Annually ☐ Biennially

IF yes, do you allow patients to be cared for by allied health professionals when you or your associates are not in the office? ☐ Yes ☐ No

Do you or a member of your family own, have an investment in, or otherwise have a business interest in any clinical laboratory, diagnostic, or testing center, hospital, surgicenter, or other business dealing with the provision of ancillary health service, equipment or supplies? ☐ Yes ☐ No

If yes, please provide the following information. (If others, please attach additional sheets.)

NAME OF ORGANIZATION	TAX ID NO.	TELEPHONE	
STREET	CITY	STATE	ZIP
TYPE OF ORGANIZATION	SIZE OF ORGANIZATION	PERCENT OF BUSINESS OWNED	
INVESTED BY PRACTITIONERS OR HOSPITALS	INVESTED BY APPLICANT		

NAME OF BUSINESS INTEREST (E.G. OWNER, PARTNER, INVESTOR.) IF OTHERS, PLEASE ATTACH.

Does your practice provide laboratory services? ☐ Yes ☐ No

If yes, please describe the type (s) of services provided:

Are you in compliance with the Clinical Laboratory Improvement Amendments of 1988 (CLIA)? ☐ Yes ☐ No

If yes, please provide a copy of your Certificate of Waiver or Certificate of Registration.

CLIA IDENTIFICATION NUMBER:

What outside labs, if any, do you use?

Does your practice provide radiology or imaging services? ☐ Yes ☐ No

If yes, please describe the type of services provided and provide copies of certification/qualification.

Which outside radiology facility do you use?

Do you perform any other types of procedures in your office utilizing equipment which requires proper instruction and inspection (i.e. pulmonary function tests, etc.)? ☐ Yes ☐ No

If yes, please list the procedures:

Section 3- Education and Training

UNDERGRADUATE EDUCATION

INSTITUTION NAME

STREET	CITY	STATE	ZIP

DEGREE	GRADUATION DATE

Dates attended (MO/YR)	FROM	TO

MEDICAL SCHOOL

INSTITUTION NAME

STREET	CITY	STATE	ZIP

DEGREE	GRADUATION DATE

Dates attended (MO/YR)	FROM	TO

Are you a graduate of a foreign medical school? *(if yes, you must provide a copy of your certificate with this application)* ☐ Yes ☐ No

If yes, are you certified by the Educational Commission for Foreign Medical Graduates (ECFMG)? ☐ Yes ☐ No

DATE	CERTIFICATE NO.

INTERNSHIP

SPECIALTY	INSTITUTION NAME

STREET	CITY	STATE	ZIP

Dates attended (MO/YR)	FROM	TO

Type of Internship: ☐ Rotating ☐ Straight

IF STRAIGHT, LIST SPECIALTY

Did you successfully complete this program? ☐ Yes ☐ No

FIRST RESIDENCY

SPECIALTY	INSTITUTION NAME

STREET	CITY	STATE	ZIP

Dates attended (MO/YR)	FROM	TO

Did you successfully complete this program? ☐ Yes ☐ No

SECOND RESIDENCY

SPECIALTY	INSTITUTION NAME		
STREET	CITY	STATE	ZIP
Dates attended (MO/YR)	FROM	TO	

Did you successfully complete this program? ☐ Yes ☐ No

FELLOWSHIP

SPECIALTY	INSTITUTION NAME		
STREET	CITY	STATE	ZIP
Dates attended (MO/YR)	FROM	TO	

Did you successfully complete this program? ☐ Yes ☐ No

SECOND FELLOWSHIP

SPECIALTY	INSTITUTION NAME		
STREET	CITY	STATE	ZIP
Dates attended (MO/YR)	FROM	TO	

Did you successfully complete this program? ☐ Yes ☐ No

BOARD CERTIFICATION

PRIMARY SPECIALTY	SECONDARY SPECIALTY		

Are you board certified in this primary specialty? ☐ Yes ☐ No

BOARD	DATE CERTIFIED	EXP. DATE	CERTIFICATE #

If not board certified in your primary specialty, are you board eligible? ☐ Yes ☐ No

DATE OF LAST EXAM	EXP. DATE

Are you board certified in your secondary specialty? ☐ Yes ☐ No

BOARD	DATE CERTIFIED	EXP. DATE	CERTIFICATE #

If not board certified in your secondary specialty, are you board eligible? ☐ Yes ☐ No

DATE OF LAST EXAM	EXP. DATE

If you are not board certified and have not applied to a board, are you planning on taking any specialty board? ☐ Yes ☐ No ☐ Not Applicable

SUBSPECIALTY BOARD

If you are planning to take the boards, please list the dates you are scheduled to sit for the exam:

BOARD	DATES

Were you ever board certified in any specialty and allowed that certification to lapse (i.e. chose not to become re-certified, failed to renew certification)? ☐ Yes ☐ No

IF SO, WHAT SPECIALTY?

If you are not board certified, please attach copies of your residency and internship certificates.

CONTINUING MEDICAL EDUCATION

List all CME credits earned during the past 3 years. (Use additional sheets if needed.)

Have you earned an AMA certificate for CME? ☐ Yes ☐ No EXP. DATE

Have you completed course work or training regarding the identification and reporting of child abuse and maltreatment as required by the State of New York? ☐ Yes ☐ No

WHERE	WHEN

If no, did you claim exemption from this requirement? ☐ Yes ☐ No
If yes, attach a copy of your Certificate of Exemption

Have you completed course work or training regarding Infectious Control practices as required by the State of New York? ☐ Yes ☐ No

WHERE	WHEN

If no, did you claim an exemption from this requirement? ☐ Yes ☐ No
If yes, attach a copy of your Certificate of Exemption

Section 4- Administrative and Billing Information

Do you presently have a computer system in your office? ☐ Yes ☐ No

If yes, does the system have electronic billing capacities? ☐ Yes ☐ No

If no, do you plan on automating within the next year? ☐ Yes ☐ No

Do you have a computerized Practice Management System? ☐ Yes ☐ No

IF YES, WHAT SYSTEM DO YOU USE?

Do you submit claim or encounter data electronically? ☐ Yes ☐ No

IF YES, WHAT SYSTEM DO YOU USE?

IF YES, WHAT CLAIM/DATE CLEARING HOUSES DO YOU NOW USE?

Section 5- Hospital Privileges

Please list all hospitals where you currently have active or adimitting privileges. Please list your **Primary Hospital** first. Also indicate the average admissions per facility per year. Please indicate status of privileges using the following key:

1	Active	5	Consulting	9	Suspended	13	Senior Staff
2	Associate	6	Temporary	10	Pending	14	Other (specify)
3	Courtesy	7	Visiting	11	Active Provisional Staff		
4	Provisional	8	Admitting	12	Courtesy Provisional Staff		

You may only use one number for each hospital. You should use the number which matches the hospital designation.
Attach additional pages as necessary.

PRIMARY HOSPITAL NAME	STATUS OF PRIV.	ADMITS/YEAR	DESCRIBE ANY RESTRICTIONS	
ADDRESS	CITY		STATE	ZIP
HOSPITAL NAME	STATUS OF PRIV.	ADMITS/YEAR	DESCRIBE ANY RESTRICTIONS	
ADDRESS	CITY		STATE	ZIP
HOSPITAL NAME	STATUS OF PRIV.	ADMITS/YEAR	DESCRIBE ANY RESTRICTIONS	
ADDRESS	CITY		STATE	ZIP
HOSPITAL NAME	STATUS OF PRIV.	ADMITS/YEAR	DESCRIBE ANY RESTRICTIONS	
ADDRESS	CITY		STATE	ZIP

Please list all hospitals where you previously held privileges Other than during your intership/residensy/fellowship. **Attach additional pages as necessary.**

HOSPITAL NAME	STATUS OF PRIV.	ADMITS/YEAR	DESCRIBE ANY RESTRICTIONS	
ADDRESS	CITY		STATE	ZIP
HOSPITAL NAME	STATUS OF PRIV.	ADMITS/YEAR	DESCRIBE ANY RESTRICTIONS	
ADDRESS	CITY		STATE	ZIP

Section 6- Professional References

Please list three professional references who are not affiliated with your practice and can attest to your professional competence currently and over the past 12 to 24 months.

NAME	TELEPHONE	
STREET		
CITY	STATE	ZIP
NAME	TELEPHONE	
STREET		
CITY	STATE	ZIP
NAME	TELEPHONE	
STREET		
CITY	STATE	ZIP

Section 7- Professional Liability Insurance Carriers

Please provide names, addresses, polity numbers, coverage limits and dates for current and all past malpractice insurance carriers. (Please give the name of your insurance carrier, not your employer's)

PRESENT PRIMARY INSURANCE CARRIER	NAME			
STREET		CITY	STATE	ZIP
POLICY NO.	COVERATE LIMITS	PHONE	DATE FROM	DATE TO

What type of coverage do you have? ☐ Claims made ☐ Occurrence ☐ Self-insured through hospital policy

PRESENT EXCESS INSURANCE CARRIER	NAME			
STREET		CITY	STATE	ZIP
POLICY NO.	COVERATE LIMITS	PHONE	DATE FROM	DATE TO

If you carried claims made insurance, did you purchase tail coverage? ☐ Yes ☐ No

PREVIOUS INSURANCE CARRIER	NAME			
STREET		CITY	STATE	ZIP
POLICY NO.	COVERATE LIMITS	PHONE	DATE FROM	DATE TO

PREVIOUS INSURANCE CARRIER	NAME			
STREET		CITY	STATE	ZIP
POLICY NO.	COVERATE LIMITS	PHONE	DATE FROM	DATE TO

If you carried claims made insurance, did you purchase tail coverage? ☐ Yes ☐ No

Section 8- Professional Liability History

Please list all past or current professional liability claims or lawsuits which have been filed against you.
(photocopy this page as needed and submit information on each claim/lawsuit)

DATE OF OCCURRENCE	DATE CLAIMS WERE FILED

PROFESSIONAL LIABILITY CARRIER INVOLVED	POLICY NUMBER

ADDRESS	CITY	STATE	ZIP

PATIENT NAME	NAME OF CLAIMANT/PLAINTIFF, IF OTHER THAN PATIENT

IDENTIFY ALL ATHER DEFENDANTS

Describe your role in the claim/lawsuit: ☐ Primary Defendant ☐ Co-defendant | NUMBER OF OTHER CODEFENDANTS

Has the claimant/plaintiff filed suit in court? ☐ Yes ☐ No

	CASE NUMBER	STATE	COUNTY/PARISH
☐ State Court			
☐ Federal Court (US District Court)	CASE NUMBER	DISTRICT	

Method of Resolution: ☐ Pending ☐ Dismissed ☐ Mediation ☐ Arbitration ☐ Judgement for plaintiff(s) ☐ Judgement for defendant(s) ☐ Settled (with prejudice) ☐ Settled (without prejudice)

AMOUNT OF SETTLEMENT/JUDGEMENT	DATE OF SETTLEMENT/AWARD

INDICATE YOUR INVOLVEMENT IN THE CASE (Attending, Consultant, etc.)

DESCRIBE THE ALLEGATIONS AGAINST YOU

DESCRIBE THE ALLEGED INJURY TO THE PATIENT

Identify your attorney for this claim/lawsuit

NAME	FIRM		

STREET	CITY	STATE	ZIP

Section 9- Disclosure Questions

1	Has your license to practice in any jurisdiction ever been denied, restricted, limited, suspended (even if the suspension was stayed) or revoked, either voluntary or involuntarily?	☐ Yes	☐ No
2	Have you ever been reprimanded, disciplined, counseled or been subject to similar action by any state licensing agency with respect to your license to practice?	☐ Yes	☐ No
3	Has your DEA or state controlled substances registration ever been restricted, limited, suspended (even if the suspension was stayed) or revoked, either voluntarily or involuntarily?	☐ Yes	☐ No
4	Are you currently under any investigation with respect to your DEA or state controlled substances registration?	☐ Yes	☐ No
5	Have you ever been denied hospital privileges or have you ever had any hospital privileges revoked, suspended (even if the suspension was stayed), reduced or nonrevewed?	☐ Yes	☐ No
6	Have you ever voluntarily relinquished or voluntarily limited any hospital privileges?	☐ Yes	☐ No
7	Have any disciplinary proceedings ever been instituted against you or are any disciplinary actions now pending with respect to your hospital privileges or your license?	☐ Yes	☐ No
8	Have you ever been denied participation in Medicare, Medicaid or any other governmental or quasi-governmental health related program?	☐ Yes	☐ No
9	Have you ever been reprimanded, censured, excluded, suspended (even if the suspension was stayed), debarred or disqualified from participating in Medicare, Medicaid or any other governmental or quasi-govermental health-related program?	☐ Yes	☐ No
10	Have you ever been requested to resign, withdraw or terminate your position with a medical partnership, professional association, heath maintenance organization, medical practice, either public or private?	☐ Yes	☐ No
11	Have any complaints ever been filed against you with a medical society or licensing authority?	☐ Yes	☐ No
12	Have any professional liability judgments ever been entered against you?	☐ Yes	☐ No
13	Have any professional liability claim settlements, not involving litigation or arbitration, ever been paid by you or paid on your behalf?	☐ Yes	☐ No
14	Have you ever been denied professional liability insurance coverage or had your professional liability insurance coverage canceled by your carrier?	☐ Yes	☐ No
15	Have you ever been convicted of a crime (other than a minor traffic offense) or do you have any criminal charges pending other than for minor traffic offenses?	☐ Yes	☐ No
16	Have you ever been refused participation in the network of a managed care organization (HMO or PPO) or been disciplined by or terminated from such a plan or organization?	☐ Yes	☐ No
17	Has any information pertaining to you ever been reported to the National Practitioner Data Bank (NPDB)?	☐ Yes ☐ No ☐ Unknown	
18	Is your physical or mental health such that it may impair your ability to practice within the scope of privileges for wich you have applied with or without reasonable accommodation?	☐ Yes	☐ No
19	Does your use of alcohol or other chemical substance(s) in any way impair or limit your ability to practice medicine with reasonable skill and safety?	☐ Yes ☐ No ☐ Not Applicable	
20	Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program?	☐ Yes ☐ No ☐ Not Applicable	
21	Are the lilmitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting or the manner in which you have chosen to practice?	☐ Yes	☐ No
22	Are you currently using illegal drugs or controlled or dangerous substances?	☐ Yes	☐ No
23	If you answered yes to the above question, are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances?	☐ Yes ☐ No ☐ Not Applicable	

Please provide an explanation for any question that you responded yes to, on a separate page.

Section 10- Work Experience/Professional History Form

LAST NAME, FIRST NAME, MIDDLE INITIAL	SOCIAL SECURITY NUMBER

Please list in chronological order, beginning with the most recent, all institutional affiliations or places of employment for the past 5 years. This includes all hospitals, teaching institutions, corporations, military assignments, or governmental agencies. (if there are any gaps, please explain on a separate page.) Please use an additional sheets for more space.

FROM MONTH/YEAR	TO MONTH/YEAR	EMPLOYER	
ADDRESS/STREET			
CITY		STATE	ZIP
PRIMARY RESPONSIBILITY			
SUPERVISOR NAME		SUPERVISOR TITLE	
FROM MONTH/YEAR	TO MONTH/YEAR	EMPLOYER	
ADDRESS/STREET			
CITY		STATE	ZIP
PRIMARY RESPONSIBILITY			
SUPERVISOR NAME		SUPERVISOR TITLE	
FROM MONTH/YEAR	TO MONTH/YEAR	EMPLOYER	
ADDRESS/STREET			
CITY		STATE	ZIP
PRIMARY RESPONSIBILITY			
SUPERVISOR NAME		SUPERVISOR TITLE	
FROM MONTH/YEAR	TO MONTH/YEAR	EMPLOYER	
ADDRESS/STREET			
CITY		STATE	ZIP
PRIMARY RESPONSIBILITY			
SUPERVISOR NAME		SUPERVISOR TITLE	
FROM MONTH/YEAR	TO MONTH/YEAR	EMPLOYER	
ADDRESS/STREET			
CITY		STATE	ZIP
PRIMARY RESPONSIBILITY			
SUPERVISOR NAME		SUPERVISOR TITLE	

SECTION 11- AUTHORIZATION, RELEASE AND ATTESTATION

I understand and agree that, as part of the recredentialing process for participation and/or clinical privileges at or with Excelsior Medical IPA, LLC (hereinafter referred to as the "Entity") and any of the Entity's affiliates, I am required to provide sufficient and accurate information for proper evaluation of my current licensure, relevant training and experience, clinical competence, health status, moral character 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 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 acknowledge accepted or rejected by each independently. I further acknowledge and understand that my cooperation in obtaining information and my consent to 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 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.

Authorizations

Investigation Concerning Application: I hereby authorize the following individuals, including the Entity, its representatives, employees,designated agent(s); the Entity's affiliates and their representatives, employees, or agent(s); the Entity's designated professional credentials verification organization (hereinafter collectively referred to as "Agents"), to investigate information, including 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 all records and documents relating to such an investigation.

Third-Party Sources: 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 and 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 and physical condition, alcohol or chemical dependency, diagnosis and treatment, ethics, or any other matter

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

Disciplinary Information: I authorize any third party at which I currently have or have had Participation and/or the third party's agents to release "Disciplinary Information," as defined below, to the Entity and/or its Agent(s). I authorize the Agent(s) to release Disciplinary Information about any disciplinary action taken against me to its participating Entities with which I have Participation, 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.

Releases

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 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 to any person, entity or governmental agency that executes an appropriate confidentiality agreement or has a legal right to know under any state or federal Law. I understand and agree that this Authorization, Attestation and Release is irrevocable for as long as this application is pending and, if accepted for Participation, for so long as the participating provider agreement remains in force and effect. I agree to execute another form of consent if law or regulation limits the application of this irrevocable authorization. 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.

Attestation

I certify that all information provided by me in my application is true, correct, and complete to the best of my knowledge and belief, and that I will notify the Entity and/or its Agent(s) within 10 days of any material changes to the information 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 on-line or in writing, and must be dated and signed by me (by a written or electronic signature). I further 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. I understand and agree that a facsimile or photocopy of this Authorization, Attestation and Release shall be as effective as the original.

Name (Print or Type):

Signature: Date: