TO AVOID DELAY IN THE PROCESSING OF THIS APPLICATION
PLEASE BE SURE TO SIGN AND DATE FOR CERTIFICATION / ATTESTATION / and RELEASE BELOW AND ANY ADDENDUMS (if applicable).

Applicants have the following rights:

- You may request to review the information submitted in support of your credentialing application;
- You may correct any erroneous information found in your credentialing files; and
- You will be notified if any information collected during the credentialing process varies substantially from the information you submitted.
- You can be informed about the status of your credentialing application.

I represent and warrant that all of the information provided and the responses given on this application are correct and complete to the best of my knowledge and belief. I understand that willful falsification or willful omission of information could result in the rejection or termination of my participation in any plan, staff or panel, in addition to penalties provided by law. I hereby authorize the hospital, CVO, credentialing entity or managed care plan, or its delegated agents, staff and representatives to collect and review all records and documents which may include records of previous education, training, and licensure; board certification status; and responses to queries to the National Practitioner Data Bank and Criminal Background Check investigations, that may be material to an evaluation of my professional qualifications and competence. I also understand that certain fields of data on this application contain time-sensitive information and must be updated from time to time, as required by specific credentialing criteria; in that regard, I authorize the entity to which this application is submitted, to collect from me and other sources, this information on an as-needed basis, and understand and agree they may communicate with me through various means, including but not limited to telephone, mail, and/or e-mail over the internet, regarding my application. I hereby release from liability the entity to which this application is submitted and their delegated agents, staff and representatives for this acts performed in good faith and without malice in connection with the evaluation of my application and my credentials and qualifications. It is my understanding that the entity to which this application is submitted shall treat the information provided herein or on any attachments hereto, and on any documents submitted or collected in support of this application as confidential and shall only disclose such information to third parties as required for purposes approved by me, my designated entity, or as authorized under state or federal law or regulation. I further release from liability any and all individuals and organizations who provide information to the entity reviewing my credentials, and its agents, staff and representatives, when released in good faith and without malice, concerning my professional qualifications, competence, ethics and character, and I hereby consent to the release of such information for purposes consistent with this application. I understand and agree that I, as an applicant, have the burden of producing adequate information for proper evaluation of my professional competence, character, ethics and other qualification and for resolving any doubts about such qualifications.

If making this application for hospital privileges, I acknowledge that I have been provided the Bylaws, Rules and Regulations of the hospital to which this application applies, and I agree to abide by them and the terms thereof without regard to whether or not I am granted clinical privileges in all matters relating to the consideration of my application for staff membership. I also pledge to provide or arrange for continuous care of my patients.

_____ _____/_____/_____
(Practitioner's Signature) (Date Signed)

_____ _____
(Practitioner's Printed Name) (Practitioner's Initials)