Please answer all of the following questions. If your answer to any of the following questions is "Yes", provide details as specified on a separate sheet. If you attach additional sheets, sign and date each sheet.

A. PROFESSIONAL SANCTIONS
1. In the past three years have you been, or are you now in the process of being denied, revoked, terminated, suspended, restricted, reduced, limited, sanctioned, placed on probation, monitored, or not renewed for any of the following? Or have you voluntarily relinquished, withdrawn, or failed to proceed with an application for any of the following in order to avoid an adverse action or to preclude an investigation or while under investigation relating to professional competence or conduct?
   a. License to practice any profession in any jurisdiction
   b. Other professional registration or certification in any jurisdiction
   c. Specially or subspecialty board certification
   d. Membership on any hospital medical staff
   e. Clinical privileges at any facility, including hospitals, ambulatory surgical centers, skilled nursing facilities, etc.
   f. Medicare, Medicaid, FDA, NIH (Office of Human Research Protection), governmental, national or international regulatory agency or any public program
   g. Professional society membership or fellowship
   h. Participation/membership in an HMO, PPO, IPA, PHO or other entity
   i. Academic Appointment
   j. Authority to prescribe controlled substances (DEA or other authority)

2. In the past three years have you been subject to review and/or disciplinary action, formal or informal, by an ethics committee, licensing board, medical disciplinary board, professional association or education/training institution?

3. In the past three years have you been found by a state professional disciplinary board to have committed unprofessional conduct as defined in applicable state provisions?

4. In the past three years have you ever been the subject of any reports to a state, federal, national data bank, or state licensing or disciplinary entity?

B. CRIMINAL HISTORY
1. In the past three years Have you been charged with a criminal violation (felony or misdemeanor) resulting in either a plea bargain, conviction on the original or lesser charge, or payment of a fine, suspended sentence, community service or other obligation?
   a. Do you have notice of any such anticipated charges?
   b. Are you currently under governmental investigation?

C. AFFIRMATION OF ABILITIES
1. Do you presently use any drugs illegally?
2. Do you have, or have you had in the last three years, any physical condition, mental health condition, or chemical dependency condition (alcohol or other substance) that affects or will affect your current ability to practice with or without reasonable accommodation? If reasonable accommodation is required, specify the accommodations required. If the answer to this question is yes, please identify and describe any rehabilitation program in which you are or were enrolled which assures your ability to adhere to prevailing standards of professional performance.
3. Are you unable to perform any of the services/clinical privileges required by the applicable participating practitioner agreement/hospital agreement, with or without reasonable accommodation, according to accepted standards of professional performance?

D. LITIGATION AND MALPRACTICE COVERAGE HISTORY (If you answer "Yes" to any of the questions in this section, please document in Section XXI. PROFESSIONAL LIABILITY ACTION DETAIL of this application.)
1. In the past three years have allegations or claims of professional negligence been made against you at any time, whether or not you were individually named in the claim or lawsuit?
2. In the past three years have you or your insurance carrier(s) ever paid any money on your behalf to settle/resolve a professional malpractice claim (not necessarily a lawsuit) and/or to satisfy a judgement (court-ordered damage award) in a professional lawsuit?
3. Are there any such claims being asserted against you now?
4. In the past three years have you ever been denied professional liability coverage or has your coverage ever been terminated, not renewed, restricted, or modified (e.g. reduced limits, restricted coverage, surcharged)?
5. Are any of the privileges that you are requesting not covered by your current malpractice coverage?

I warrant that all the statements made on this form and on any attached information sheets are true and correct. I understand that any material misstatements in, or omissions from, this statement constitute cause for denial of membership or cause for summary dismissal from the entity to which this statement has been submitted.

Applicant's Signature: __________________________ Date________________________

Type or Print name here________________________

OVER
PRACTITIONER AUTHORIZATION AND RELEASE OF INFORMATION FORM

Modified Releases Will Not Be Accepted

By submitting this Authorization and Release of information form I understand and agree as follows:

1. I understand and acknowledge that, as an applicant for medical staff membership and/or participating status with the Healthcare Organization(s)* indicated for initial credentialing or recredentialing, I have the burden of producing adequate information for proper evaluation of my competence, character, ethics, mental and physical health status, and or other qualifications.

2. I further understand and acknowledge that the Healthcare Organization(s) or designated agent will investigate the information in this application. By submitting this Authorization and Release form, I agree to such investigation and to the disciplinary reporting and information exchange activities of the Healthcare Organization(s) as part of the verification and credentialing process.

3. I authorize all individuals, institutions and entities of organizations with which I am currently or have been associated and all professional liability insurers with which I have had or currently have professional liability insurance, who may have information bearing on my professional qualifications, ethical standing, competence, and mental and physical health status to release the aforementioned information to the designated Healthcare Organization(s), their staffs and agents.

4. I consent to the inspection of records and documents that may be material to an evaluation of qualifications and my ability to carry out the clinical privileges or provide services I request. I authorize each and every individual and organization in custody of such records and documents to permit such inspection and copying. I am willing to make myself available for interviews if required or requested.

5. I release from any liability, to the fullest extent permitted by law, all persons for their acts performed in a reasonable manner in conjunction with investigating and evaluating my application and qualifications, and I waive all legal claims against any representative of the Healthcare Organization(s) or their respective agent(s) who act in good faith and without malice in connection with the investigation of this application.

6. For healthcare organizations, I acknowledge that I have been informed of, and hereby agree to abide by, the bylaws, rules, regulations and policies.

7. I agree to abide by the policies, procedures, and or contractual agreements of the Healthcare Organization(s) from whom I am seeking initial or recredentialing.

8. I attest to the accuracy and completeness of the information provided. I understand and agree that any misstatements in or omissions from the attestation and attachments hereto may constitute cause for denial of the application or summary dismissal or termination of membership/clinical privileges/participation agreement.

9. I agree to exhaust all available procedures and remedies as outlined in the bylaws, rules, regulations, and policies, and/or contractual agreements of the Healthcare Organization(s) where I have membership and/or clinical privileges/participation status before initiating judicial action.

10. I understand that completion and submission of the Authorization and Release form does not automatically grant me membership or clinical privileges/participating status with the Healthcare Organization(s)* indicated on the Attestation and Release form.

11. I further acknowledge that I have read and understand the foregoing Authorization and Release. A photocopy of this Authorization and Release shall be as effective as the original and authorization constitutes my written authorization and request to communicate any relevant information and to release any and all supportive documentation regarding this application/attestation.

Print Name

Here: ________________________________

Signature: ____________________________

(Stamped signature is not acceptable)

Date: ________________________________

*Healthcare Organization (e.g. hospital, medical staff, medical group, independent practice association, professional review organization health plan, health maintenance organization, preferred provider organization, physician hospital organization, medical society, credentials verification organization, professional association, medical school faculty position or other health delivery entity or system).